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ABSTRACT

Joint training of rehabilitation counselors and social caseworkers has the potential for developing and improving professional techniques to increase the number of handicapped welfare recipients who can be rehabilitated. A regional curriculum for Virginia, West Virginia, Maryland, Delaware, Pennsylvania, and the District of Columbia, this joint training effort is designed: (1) to foster awareness, interest and cooperation between sponsoring agencies and employers of the disabled; and (2) to strive to develop a program effective in helping disabled welfare applicants and recipients overcome barriers to rehabilitation. The course of study: (1) facilitates communication and understanding between agencies; (2) clarifies the teamwork approach and problems encountered in joint-agency efforts; and (3) provides the Department of Welfare and Division of vocational Rehabilitation with an interagency joint orientation. The units of study outlined include role identification, client evaluation, delivery of service system, community resources, and feedback system between cooperating agencies. (Author/NMF)

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AN OUTLINE FOR A COURSE OF STUDY

JOINT TRAINING

DEPARTMENT OF WELFARE AND DIVISION OF VOCATIONAL REHABILITATION

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and

Jack Reno, Assistant Program Director

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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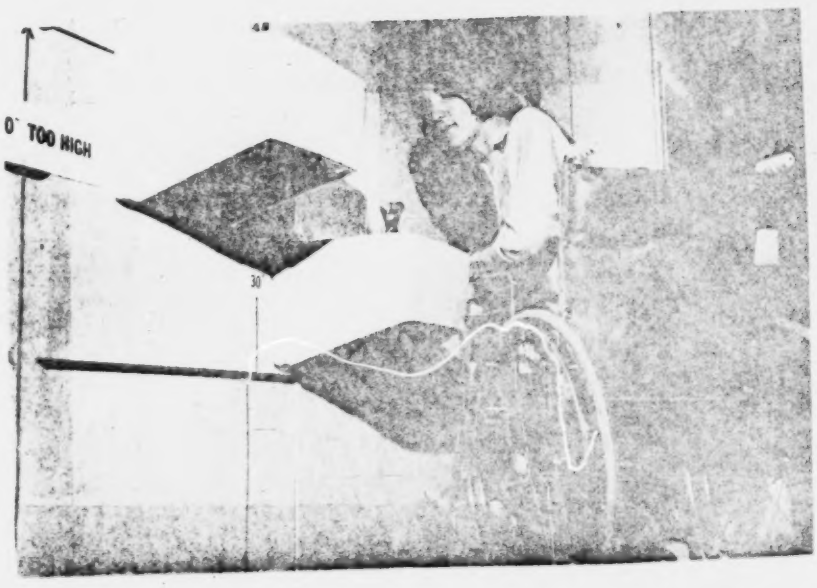
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FOREWORD

An effort will be made to serve 200,000 public welfare clients in fiscal year 1972 and, hopefully, rehabilitate 58,000 public welfare clients during the fiscal year. To meet this challenge will require the best efforts of social caseworkers and rehabilitation counselors.

Joint training of rehabilitation personnel and welfare personnel has the potentiality of developing and improving professional techniques, methodology, cooperation, alteration of attitudes, etc., which will increase the number of handicapped persons on welfare who can be rehabilitated. This calls for total agency involvement along with innovative projects, creative approaches, special staff and assignment of high priority to this endeavor.

The purpose of this course of study for joint-training of welfare-rehabilitation staff is to serve as a guide for providing these personnel with educational experiences so as to better prepare the workers to serve themselves, their clients, their agencies, and their community.

This outline may not be necessarily adhered to completely; nor is it totally inclusive of what may occur in a specific training session. Flexibility in coverage is maintained so as to insure the program staff and resource persons opportunities to respond to employees' requests and needs.

Specific objectives of this joint training effort will be:

(1) To develop a greater awareness, interest, commitment and involvement between the sponsoring agencies and employers in the rehabilitation of the disabled welfare applicant and/or recipient.

(2) To identify and develop an effective program for helping the disabled welfare applicant and/or recipient in overcoming barriers to successful rehabilitation to their greatest potential.

(3) To help facilitate communication between the sponsoring agencies and foster mutual understanding.

(4) To clarify the teamwork approach so that all personnel involved can contribute more effectively in the delivery of services to disabled welfare applicants and/or recipients.

(5) To clarify problems encountered in joint-agency efforts on behalf of disabled welfare applicants and/or recipients and develop ways and means of resolving these problems.

(6) To provide interagency joint orientation to special project goals, to jointly develop PA-VR screening, to develop mutual guidelines, to implement new aspects of programs, and to exchange agency visits to program operations.

In short, this course content and the training situation in which it occurs hopes the employee can better find out what Vocational Rehabilitation and Public Welfare are; who he is in Vocational Rehabilitation and Public Welfare; and what he as a person has to offer to others in conjunction with the Vocational Rehabilitation Agency and the Public Welfare Agency.

William R. Phelps
Editor

PREFACE

This document contains efforts of an Ad Hoc Committee for the development of a Regional curriculum for Joint Training of PA-VR Personnel. (Region III, including Virginia, West Virginia, Maryland, Delaware, Pennsylvania, and the District of Columbia) The charges to this Ad Hoc Committee were as follows:

1. The development of an overall regional comprehensive curriculum relating to commonality of needs, problems, etc.; to foster better working relationships between agencies so as to provide more effective joint services to disabled welfare recipients and/or applicants.

2. The development of specific training models to be a part of the core curriculum; yet take into account variability and uniqueness of needs of various states within Region III.

3. The development of a training model applicable to various course content to deal with: (a) concepts and knowledge, (b) attitudes, and (c) skills.

4. The development of instructional and evaluation methods.

The curriculum presented herein represents the combined thinking of the Ad Hoc Committee and its group workshop sessions. The Committee met twice for four (4) work sessions over a twelve month period.

Special thanks are due all Committee members; Mr. Seth Henderson and Lee Wolf of the RSA Regional Office; and Miss Joann Bowyer, who typed the manuscript.

William R. Phelps
Editor

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I. PHILOSOPHY AND PURPOSE

A. Introduction to the Department of Public Welfare

1. History of Welfare

a. Chronology of Legislation

(1) 1935 - Social Security Act

(2) 1952 - Amendments to the Social Security Act

(3) 1960 - Amendments to the Social Security Act

(4) 1962 - Amendments to the Social Security Act

(5) 1965 - Amendments to the Social Security Act

(6) 1967 - Amendments to the Social Security Act

b. Legislation Related to Welfare

(1) 1964 - Economic Opportunity Act

(2) 1970 - Talmadge Amendments

(3)

(4)

c. Significant State Legislation

2. The Welfare Philosophy (See Rehabilitation Philosophy)

3. Agency Administrative Organization

a. Public Welfare - A State-Federal Program

(1) The Department of Health, Education, and Welfare

(a) Social and Rehabilitation Services

b. Organizational Objectives

c. Administrative Structure

d. Department of Public Welfare

(1) Concept of Line and Staff

(2) Agency Organizational Structure

(a) State organization

(b) Regional organization

(c) Local organization

B. Introduction to the Department of Vocational Rehabilitation

1. History of Rehabilitation

a. Chronology of Legislation - Legislative Developments since 1943

(1) The Vocational Rehabilitation Act Amended, 1943, Public Law 78-113

(2) The Vocational Rehabilitation Act Amended, 1954, Public Law 83-565

(3) The Vocational Rehabilitation Act Amended, 1965, Public Law 89-333

(4) The Vocational Rehabilitation Act Amended, 1967, Public Law 90-99

(5) The Vocational Rehabilitation Act Amended, 1968, Public Law 90-391

b. Legislation Related to Rehabilitation

(1) Public Welfare Amendments, 1962. Public Law 87-543

(2) Economic Opportunity Act, 1964. Public Law 88-452

(3) Social Security Act Amended, 1965. Public Law 89-97

(4) Correctional Rehabilitation Act, 1965. Public Law 89-179

(5) Recent Legislation

2. The Rehabilitation Philosophy (See Welfare Philosophy)

a. Every member of a democratic society has a right to the opportunity to earn a living and make his contributions to society.

b. Society has the obligation to equalize, as best it can be special services, the disabled person's opportunity to earn a living equal to the opportunity possessed by the non-disabled members of society.

c. The Rehabilitation Counselor should have an abiding interest in the total person. He must be client oriented. The agency functions to serve clients.

d. Costs, numbers, productions are secondary to helping the individual.

e. As Rehabilitation Counselors, we must not do for a disabled individual that which he can do for himself.

f. Rehabilitation seeks to maintain health dependency whenever possible.

g. The fulfillment of the purpose of rehabilitation is contingent upon extending its services to all who need them.

h. Rehabilitation services should provide disabled persons the opportunities to reach their highest level of attainment.

i. The rehabilitation counselors seek to help clients rehabilitate themselves.

j. The bulk of disabled persons are unemployable, without rehabilitation service, as far as present employment practices are concerned.

k. The many and varied professional disciplines are partners in services to the disabled.

l. To "treat the whole man," each person or profession must see themselves as part of a total team effort whose function is to help others help themselves.

m. Rehabilitation personnel must continue to grow professionally. Rehabilitation counseling is a continual learning process.

n. Effective rehabilitation requires continual self-analysis, stimulation and evaluation.

o. Effective rehabilitation requires qualitative and quantative standards of performance.

p. Effective rehabilitation requires public understanding and support.

3. Agency Administrative Organization

a. Vocational Rehabilitation - A State-Federal Program

(1) The Department of Health, Education, and Welfare

(a) Social and Rehabilitation Services

Rehabilitation Services Administration (ten federal regions) RSA Region III is comprised of the State Rehabilitation Agencies of Maryland, the District of Columbia, Virginia, West Virginia, Pennsylvania, and Delaware.

(b) Organizational Objective: To restore disabled and handicapped persons to productive, meaningful, dignified, gainful employment.

(c) Administrative Structure: (A means to an end.) The Agency's program of Rehabilitation Services is a bridge between disability, unemployment, and dependency on the one hand and restored health, gainful employment, personal dignity, and economic independence on the other. The Agency's program of Rehabilitation Services and its organizational machinery are tangible expressions of the philosophy of rehabilitation.

d. Division of Vocational Rehabilitation (A Division of the State Board of Vocational Education).

(1) The Concept of Line and Staff

(2) Agency Organizational Structure

(a) State Organization

(b) Regional Organization (Rehabilitation Services Division)

(c) Local Organization (Geographical coverage of districts and territories)

(d) Specialized Facilities

(e) Specialized Programs

II. ROLE IDENTIFICATION

A. Social Service Worker

The social service worker helps the individual or family secure the needed services. This includes assessing the situation, knowing the alternative resources, preparing and counseling the client and family, contacting the appropriate sources, and assuring that the client gets there and is served. These duties may be broken down and assigned to aides. The social service worker is the focal point for the provision of social services.

B. Rehabilitation Counselor

The VR Counselor will be responsible for the vocational assessment and recommending the employment objective. He will secure the services necessary to carry out the client's rehabilitation plan. The VR Counselor, Social Service Worker, and the Rehabilitation Aide will make a joint decision as to who and how this plan will be carried out. The VR Counselor, Rehabilitation Case Aide and client, in cooperation with the Social Service Worker, will develop a plan to provide the services necessary to achieve the employment objective. The Rehabilitation Counselor is the coordinator for the provision of rehabilitation services.

C. Rehabilitation Case Aide

The Rehabilitation Aide will make a home visit to determine the applicant's readiness for VR services in this program. This involves gathering information, assessing client or community problems, recommending alternatives and priorities and making decisions for action. Case Aides are persons who can talk the language of the client, understand the client's culture and be his agent to help him to meet his needs. In other words, the Aides are to be persons whom the client can trust and through whom they can relate to all of the specialists and agencies. The Rehabilitation Aide will report his findings to his supervisor.

The Rehabilitation Case Aide will discuss with each of the two local agency coordinators (Counselor and Social Service Workers) and other appropriate agency personnel the kind of supportive help that the person and family may need and who will provide the necessary services.

D. Other staff (e.g., Welfare Case Aide, Project Director, Supervisor, Coordinator, volunteers, Eligibility Specialists, etc.).

E. THE SOCIAL SERVICE PROCESS

1. Basic Functions of Social Work

a. Restoration

(1) Curative (Elimination of factors causing the functional breakdown)

(2) Rehabilitation (To organize and rebuild interactional patterns)

b. Provisions of Resources

(1) Developmental

(a) Further effectiveness of existing social resources or help the person obtain increased capacity for social interaction

(2) Education

(a) Acquaint the public with needs and conditions for new and changing social resources

C. Prevention of Social Dysfunction

(1) Early discovery, control, and elimination of conditions and situations which could impede effective social functioning

(2) Prevention of problems in the interaction between persons and groups

(3) Prevention of social problems

D. Characteristics of Social Work

(1) Focus on wholeness and totality of a person's behavior

(2) Emphasis on the family in its role of influencing behavior

(3) Utilizing community resources in helping people solve their problems

(4) Using supervision for the guidance and direction of individual workers

(5) Three basic methods of social work: Case work, group work, community organization

(6) Key to social work process is relationship

(7) Social work has an orientation in psychiatric concepts and places stress on understanding people

(8) The social in social work emphasizes stress on social interaction and resultant social functioning and malfunctioning

(9) Basic aim is to help client help himself

2. The Social Service Process

A. Eligibility Requirements for DPW Services

Eligibility requirements to receive public assistance

payments and social services from the Departments of Public Welfare are based on need. Public Assistance is a money payment provided through Federal, State and local appropriation to needy individuals and families.

(1) Need is determined on the basic items of food, shelter, clothing, household maintenance and replacements, insurance premiums, personal care and school supplies.

(2) Need is considered to exist when a person's income and other resources are below the minimum determined by the Department to be essential to meet the cost of daily living.

(3) Other conditions of eligibility that must be met to receive public assistance include: Age, physical condition, earnings, relationship to children, reason children are deprived of support.

(4) Public Assistance programs eligible for this program are:

(a) Old Age Assistance (OAA)

(b) Public Assistance to the Blind (AB)

(c) Aid to the Permanently and Totally Disabled (APTD)

(d) General Public Assistance (GPA)

(e) Aid to Families with Dependent Children (AFDC)

(f) Aid to Families with Dependent Children - Foster Care (AFDC-FC)

B. Case Finding

(1) Review all existing caseloads for immediate referrals and potential referrals

(2) All new applicants who allege disability or those who are suspected of having a disabiltiy be referred at intake

C. Case Referral

(1) Early identification of potential clients by PA workers for VR services

(2) Initial identification by PA agency

(a) Jointly develop criteria for pre-screening

(b) Pre-Screening counseling

(c) Referral

(d) Joint planning (Diagnostic or evaluative phase)

D. The Rehabilitation Service Process

(1) Basic Functions of Rehabilitation Counseling
(a) Case Status Classifications and Caseload Management

STATUS	TITLE
00	Referral
02	Applicant
04	Six-month Extended Evaluation
06	Eighteen-month Extended Evaluation
08	Closed After Referral or Extended Evaluation
10	Plan Development
12	Plan Completed
14	Counseling and Guidance Only
16	Physical Restoration
18	Training
20	Ready for Employment
22	In Employment
24	Service Interrupted
26	Closed Rehabilitated
28	Closed Not Rehabilitated AFTER Rehabilitation Plan Initiated
30	Closed Not Rehabilitated BEFORE Rehabilitation Plan Initiated

(b) Public Relations

(c) Office Management

(d) Making and Utilizing Reports

(e) Case Recording

(1) Purpose of Case Recording System

(a) Facilitate Client-Study and Bring into Focus Pertinent Data

(b) Improvement of Staff and Programs

(c) Administrative Purposes

(2) Guides for A Case Recording System

(a) Recording on Established Forms
(b) Summary Recording
(c) Caption Heading Recording
(d) Narrative Recording
(e) Recording for Research Purposes

(3) Critical Points in Case Recording

(a) Determining Eligibility
(b) Client's Perception of Problems
(c) Counselor-Client Relationship
(d) New Information
(e) Case Evaluation
(f) Discussion of Alternate Vocational Objectives
(g) Plan Justification
(h) Changes in the Rehabilitation Plan
(i) Case Supervision
(j) Casework Interruptions
(k) Case Re-evaluation
(l) Loss of Contact with the Client
(m) Readiness for Employment
(n) Job Placement Plan
(o) Case Closure

E. Rehabilitation Counseling As a Profession

(1) The Counselor Role vs. the Coordinator Role

(2) Professional Affiliations

(a) National Rehabilitation Counseling Association
(b) American Rehabilitation Counseling Association
(c) American Psychological Association
(d) American Personnel and Guidance Association
(e) National Rehabilitation Association

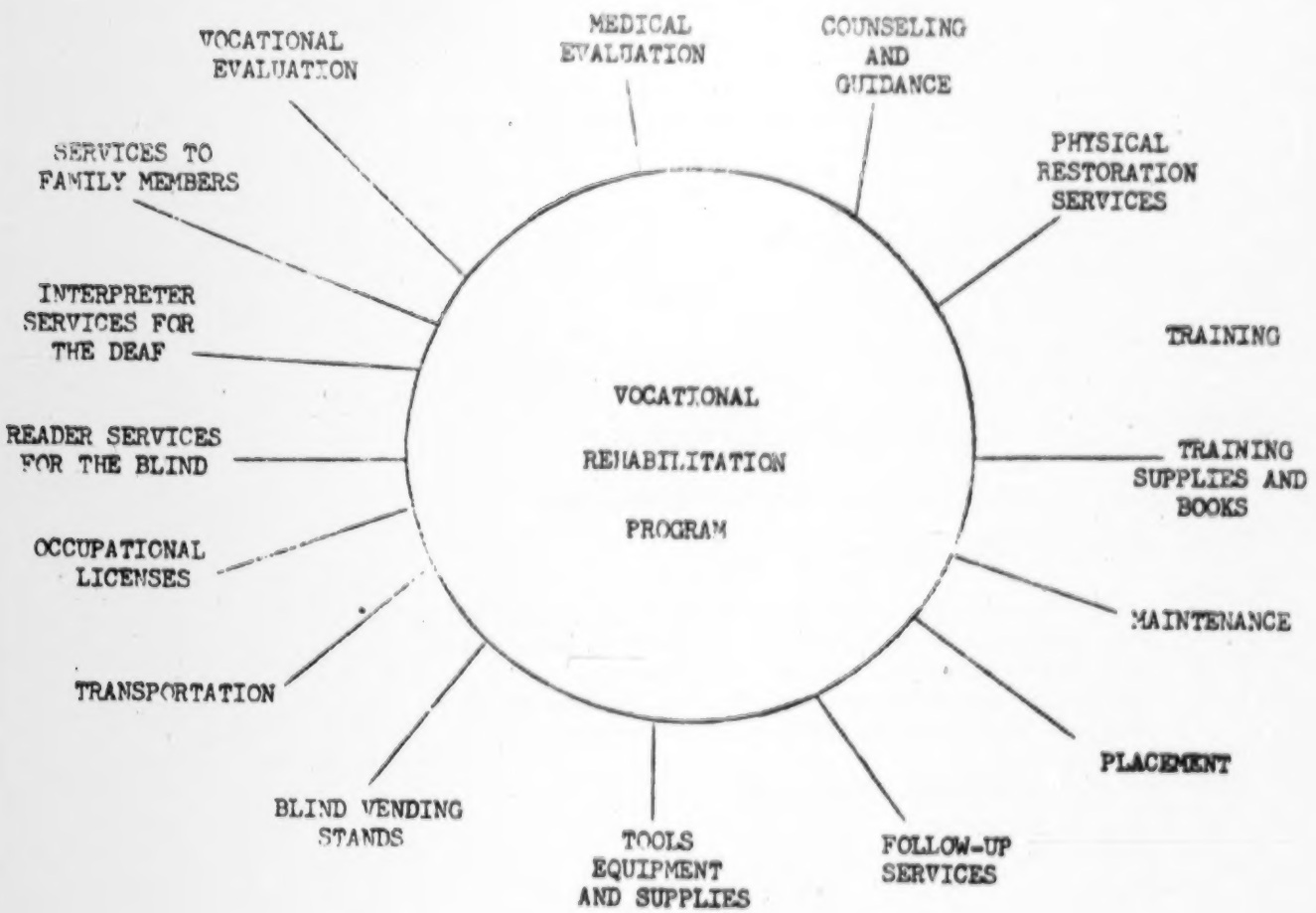
(3) Counselor Advisory Committees

(4) Counselor Education

THE ROLE AND FUNCTION

OF

REHABILITATION COUNSELING



III. Case Finding and Referral Process

A. Review all existing caseloads for immediate referrals and potential referrals

B. All new applicants who allege disability or those who are suspected of having a disability be referred at intake

C. Client Procedures and Services

1. Early identification of potential clients by PA workers for VR services

2. Initial identification by PA agency-caseworker identifies for referral to VR

(a) Jointly develop criteria for pre-screening

(b) Pre-Screening counseling

(c) Referral

(d) Joint planning (diagnostic or evaluative phase)

D. Report back on Referral

(1) At referral

(2) At Closure

E. Eligibility Requirements for DVR Services

1. The presence of a physical, mental, or emotional disability with resulting functional limitation

2. The existence of a substantial handicap to employment caused by the limitation resulting from such a disability; and

3. A reasonable expectation that vocational rehabilitation services may render the individual fit to engage in a gainful occupation.

4. Services Available

The services listed below are provided and paid for by the Division of Vocational Rehabilitation to the extent that the individual is unable to pay for them or there is no other source for payment. The Vocational Rehabilitation Counselor has the obligation to explore and utilize all other available resources. If there are no available resources, the Vocational Rehabilitation Counselor may provide the services required to carry out the client's rehabilitation plan.

(a) The following services may be provided without the determination of economic need:

(1) Diagnostic medical, psychiatric, and psychological examination necessary for determining eligibility, the extent of disability, possible hidden or secondary disabilities, and the work capacity of the individual.

(2) Vocational diagnosis, which includes a study of the personal and social history, work experience, educational background, interests, abilities, aptitudes, and personal characteristics of the individual.

(3) Individual counseling, guidance, and vocational evaluation to determine the services required to meet the needs of the client and to assist him in the selection of a suitable field of work. The Rehabilitation Counselor, the caseworker, and the client will develop a plan to provide the services necessary to achieve the employment objective.

(4) Personal adjustment training, if needed, to meet the needs of daily living, to develop proper work habits, and to modify personal attitudes which interfere with vocational and social adjustment.

(5) Appropriate vocational training for the selected job objective.

(6) Transportation as required during evaluation, physical restoration and training.

(7) Placement in suitable employment. Included are, self-employment and employment as a homemaker or unpaid family worker.

(8) Follow-up after placement to insure that the rehabilitated worker has adjusted to the job to his own satisfaction and to that of the employer, and that the employment is consistent with the client's physical and mental capacities.

(9) Initial stocks and supplies, and management services and supervision, for small businesses, including the acquisition of vending stands by the State Agency.

(10) Reader services for the blind and interpreter services for the deaf.

(11) Services to members of a handicapped individual's family when such services will contribute substantially to the rehabilitation of the handicapped individual.

(12) Other goods and services necessary to render a handicapped person employable.

(b) Provision of the following services are dependent upon the determination of economic need.

(1) Hospitalization, medical, surgical, and psychiatric services as needed, to correct or modify, within a reasonable length of time, a disability which constitutes a substantial handicap to employment.

(2) Physical, occupational, speech and hearing therapy, as part of treatment when needed.

(3) Prosthetic and orthotic appliances such as, limbs, hearing aids, trusses, braces, eye glasses, wheelchairs, and similar devices needed to increase work ability, and/or to obtain or retain employment.

(4) Maintenance, if necessary, and not allowable through the Department of Social Services during treatment or training.

(5) Occupational tools, equipment, and licenses as necessary for placement and employment.

c. Selection of Individuals for Referral

The Division of Vocational Rehabilitation, through its Vocational Rehabilitation Counselor, is responsible for determining an individual's eligibility for its service. It is not possible to set forth criteria that will cover all individuals possibly eligible for the Division of Vocational Rehabilitation services. Referral may be considered for all individuals of working age, with a physical, mental, or emotional disability who may have a potential for employment or need for services, and an interest in referral. An individual considered by the Division of Vocational Rehabilitation for services must have a disability which meets at least one of the following conditions:

1. Contributes to his not having acquired a marketable skill or not having made a suitable vocational adjustment to his disability.

2. Requires further medical evaluation prior to placement in order to determine employability and work limitations and restrictions.

3. May be eliminated, modified, or substantially ameliorated by medical or psychiatric treatment.

4. Contributes to his being in danger of losing employment.

5. Requires the provision of a prosthetic, orthotic, or cosmetic appliance to compensate for the loss of sensory function of a member of the body and the replacement of an appliance and/or training of the individual in its use.

6. Requires placement in a sheltered workshop or homebound employment due to the severity of the disability.

7. Has not prevented a successful work experience, but the client does not have the essential tools, equipment, license, or proper certification to engage in his field of work.

8. Results in inadequate wage from self-employment and indicates the need for a reevaluation to determine whether or not the individual should continue the same employment.

9. Has not prevented the individual from learning a skill, but, in order to successfully compete with other workers, he needs a refresher course in the field of work in which he has been or is employed.

10. Handicaps him, but who after training remains unemployed even though there have been repeated attempts at placement.

d. Scope of the Counseling Relationship

Standards and policies have been established for maintaining a counseling relationship throughout a handicapped individual's program of services which will assure (a) adequate counseling services to the individual in connection with his vocational potentialities and the health, personal and social problems related to his vocational adjustment; and (b) necessary guidance to him in developing an understanding of his capacities and limitations in selecting a suitable occupational goal, and in using appropriately the medical services, training, and other rehabilitation services needed to achieve the best possible vocational adjustment. "Rehabilitation Counseling" within the above context of the counseling relationship is represented in broad terms as a relationship that treats a variety of individual situations throughout the program of services to the client, including follow-up after placement and specifically encourages client involvement in making sound decisions with respect to his own problems and solutions. Therefore, it is not restricted to a discrete portion of the rehabilitation process; it is a relationship that should continue throughout the case process. It is through this relationship that the counselor helps the client develop an understanding of his particular situation and needs, and assists him in maximum utilization of rehabilitation services in order to achieve the best possible vocational adjustment.

The following services are indicative of rehabilitation counseling which may be considered as substantial:

1. Assisting the client in understanding his capacities, aptitudes, and interests throughout the rehabilitation process on the basis of evaluations of the client's progress toward the selected goals.

2. Helping the client to understand his limitations, and health, personal and social problems related to his vocational adjustment.

3. Assisting the client to adjust to situations encountered in achieving his rehabilitation, e.g. control of anxieties concerning physical restoration, development of appropriate study and work habits, improving personal appearance, managing finances, preparation for job interviews and tests, devising effective interpersonal relationships, insight into the world of work, and the like.

4. Assisting the client in understanding the services available from the rehabilitation agency and other community resources, and how they can best be obtained and utilized in his vocational adjustment.

5. Assisting the client in selecting suitable and realistic vocational goals.

6. Planning with the client, and others when necessary, a program for the attainment of selected vocational goals.

7. Working with family-members, relatives, and various segments of the community to aid in the individual's vocational adjustment.

8. Continuing follow-up relationship with the client, employer, and others, when necessary, to assure suitability of the occupation.

It is recognized that all of the above considerations will not be present in every counseling situation and that others may evolve. They are descriptive, however, of the nature and scope of rehabilitation counseling.

e. Placement

1. Securing suitable employment requires the development of a plan with the client which ordinarily includes some combination of the following:

(a) An evaluation of the client's job readiness is made.

(b) The client is guided in development and execution of a plan for job seeking activities.

(c) The client is instructed in making job applications and his conduct and appearance during interviews.

(d) Employers are contacted; job prospects explored and vital information regarding placement of the client is provided to the prospective employer.

(e) The client is registered with the State employment service.

(f) Jobs are analyzed and modified, and employers or supervisors are consulted, advised, and trained, as required.

(g) Efforts in the area of selective placement are pursued in cases of severely handicapped clients.

(h) Provisions for post-placement follow-up activities are made.

2. Suitable Occupation - An occupation is considered suitable when, after a reasonable period after placement (thirty days is considered minimum) it has been confirmed that the following conditions have been met insofar as possible.

(a) The client and employer are mutually satisfied.

(b) The client is maintaining adequate interpersonal relationships and acceptable behavior in the job environment.

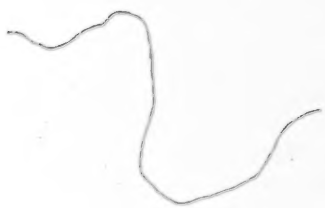
(c) The occupation is consistent with the client's capacity and abilities.

(d) The client possesses acceptable skills to perform or continue the work satisfactorily.

(e) The employment and working conditions will not aggravate the client's disability in the job situation and will not jeopardize the health or safety of himself or others.

(f) The wage and working conditions conform to State and Federal statutory requirements.

(g) The employment is regular, reasonably permanent, and the client receives a wage commensurate with that paid other workers for similar work.



F. Eligibility Requirements for DPW Services

Eligibility requirements to receive public assistance payments and social services from the Departments of Public Welfare are based on need. Public Assistance is a money payment provided through Federal, State and local appropriation to needy individuals and families.

1. Need is determined on the basic items of food, shelter, clothing, household maintenance and replacements, insurance premiums, personal care and school supplies.

2. Need is considered to exist when a person's income and other resources are below the minimum determined by the Department to be essential to meet the cost of daily living.

3. Other conditions of eligibility that must be met to receive public assistance include: age, physical condition, earnings, relationship to children, reason children are deprived of support.

4. Public Assistance programs eligible for this program are:

   (a) Old Age Assistance (OAA)

   (b) Public Assistance to the Blind (AB)

   (c) Aid to the Permanently and Totally Disabled (APTD)

   (d) General Public Assistance (GPA)

   (e) Aid to Families with Dependent Children (AFDC)

   (f) Aid to Families with Dependent Children - Foster Care (AFDC-FC)

5. Services Provided by DPW

   (a) Coordinating agency of social services and public assistance activities. -- The State Department shall be the central, coordinating and directing agency of all social service and public assistance activities in this State including Aid to Families with Dependent Children, Old Age Assistance, Aid to the Permanently and Totally Disabled, Public Assistance to the Needy Blind, General Public Assistance, General Public Assistance to Employables, Child Welfare Services and any other social services and public assistance activities financed in whole or in part by the State Department.

   (b) Financial Assistance -- Public Assistance grants are made monthly through local departments of social services to needy individuals and families who are without sufficient income and other resources to meet the cost of food, shelter, clothing and other essentials of living in comparison to Public Assistance allowances. In the adult categories, Public Assistance grants are made to eligible individuals and families as follows:

(1) Old Age Assistance (OAA) is available to persons 65 years of age or older. These persons are handicapped due to age and/or physical or mental disabilities.

(2) Public Assistance to the Needy Blind (PANB) is available to persons who are blind as determined by medical definition -- central visual acuity of 20 over 200 or less in the better eye with correcting glasses. Eligibility on the factor of blindness is determined by a State supervised Ophthalmologist on the basis of a report of eye examination made by one of the examiners specified by the State.

(3) Aid to the Permanently and Totally Disabled (APTD) is available to needy persons between the ages of 18 and 64 years who are permanently and totally disabled as determined by the State Review of medical and social information. Permanent and total disability is defined as any physical or mental impairment or disease which continuously precludes the individual from engaging in any useful occupation including homemaking.

(4) General Public Assistance (GPA) is available to needy persons not eligible for a Federal category of public assistance and are unemployed or employed only part time due to illness or disability.

In addition to the regular Public Assistance payments, local departments of social services certify Public Assistance recipients for Medical Assistance under the program.

The Food Stamp Program is also available to persons in receipt of Public Assistance if they meet the additional eligibility requirements for that program. Medical Assistance and Food Stamps are available also to persons, including the handicapped, who have net income over that allowed for Public Assistance but within the higher income scale allowed for each of these programs.

Public Assistance payments are also made to handicapped children and parents who are included in families receiving grants under the Aid to Families with Dependent Children category.

(c) Services To Children

(1) Aid to Families with Dependent Children (AFDC) -- Income maintenance function and social services are seperate which means that generally the request for social services is voluntary on the part of the recipient. An exception is voluntary service of the unemployed, able-bodied male and the unemployed youth 16 and over who is not in school. Consequently, the local departments of social services would not be able to provide the services to anyone unless it was requested.

(2) Foster Care -- These children are committed to the local departments of social services as dependent or neglected children. Or they may be children who for some reason cannot remain in their own homes. Resources in the Foster Care Program that have special significance are as follows: an instance where children need special supervision it is possible to pay a higher rate in Foster Care to the foster parents. Emergency Foster Care for those children who are abandoned or left alone without proper supervision or a child who has special needs and the local department is unable to secure or provide the resources within their own program it is possible to purchase care from other agencies and institutions.

(3) Protective Services (including Child Abuse) -- It is mandatory by law for certain professional persons working with children to refer to local departments of social services incidents of suspected child abuse. The incident is investigated with subsequent referral to the State's Attorney or to the local department for services.

(d) Other Social Services

(1) Family Planning

(2) Homemaker Service

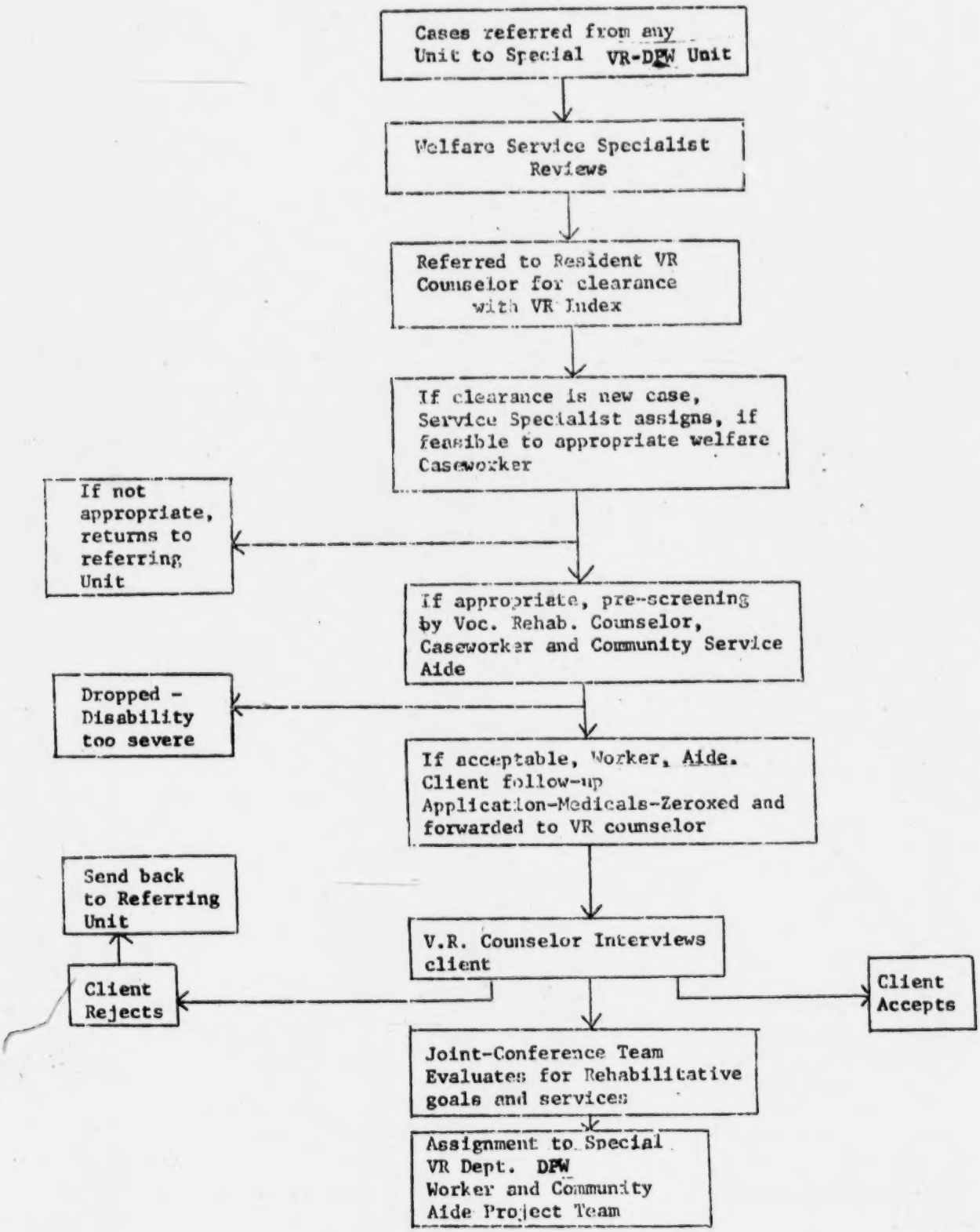
(3) Adoption

(4) Legal Services Program

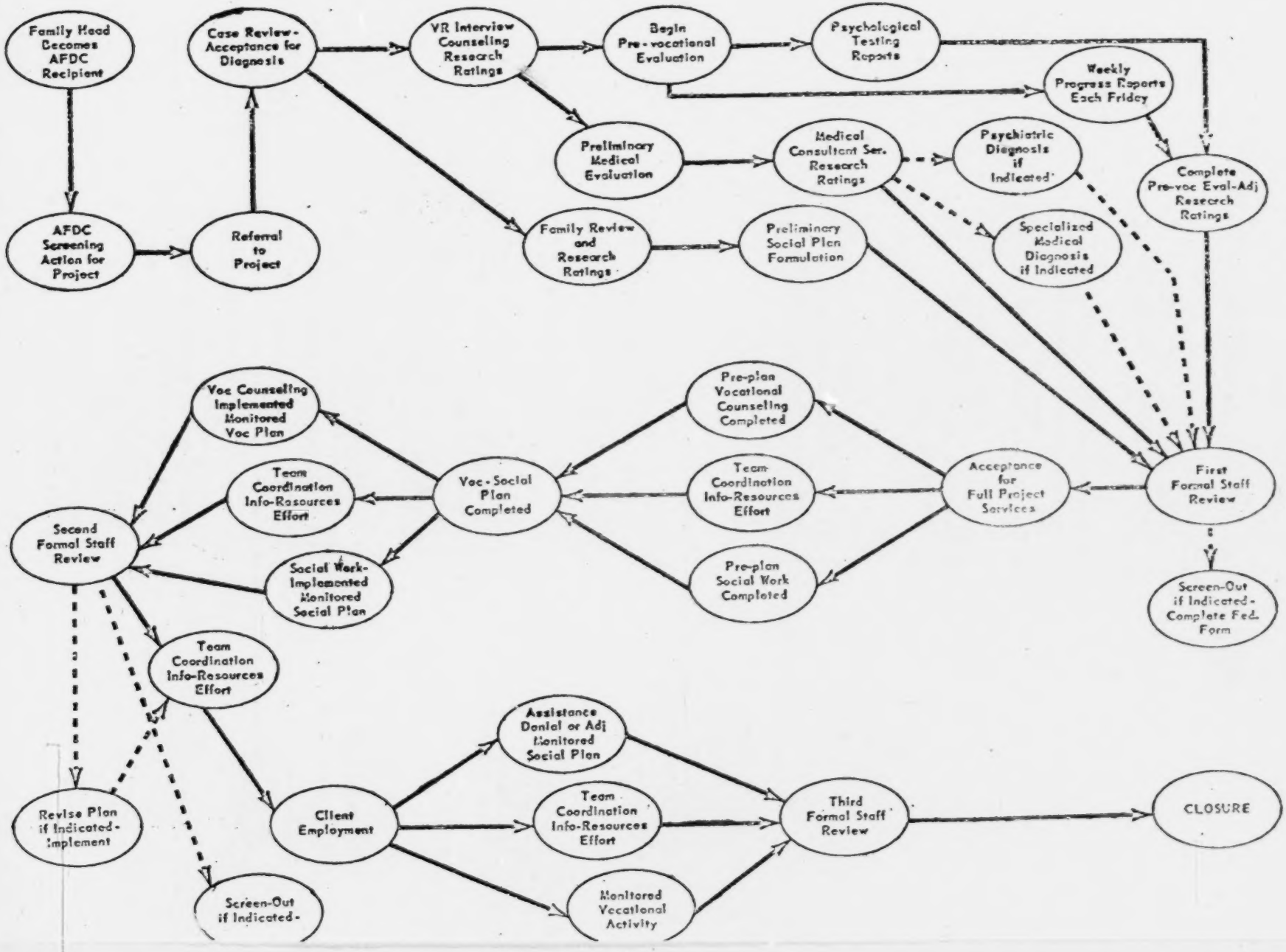
(5) Day Care for Children

(6) Crippled Children's Program

SAMPLE MODEL OF POSSIBLE TEAM APPROACH FLOW CHART


Cases referred from any Unit to Special VR-DPW Unit
Welfare Service Specialist Reviews
Referred to Resident VR Counselor for clearance with VR Index
If clearance is new case, Service Specialist assigns, if feasible to appropriate welfare Caseworker
If not appropriate, returns to referring Unit
If appropriate, pre-screening by Voc. Rehab. Counselor, Caseworker and Community Service Aide
Dropped - Disability too severe
If acceptable, Worker, Aide. Client follow-up Application-Medicals-Zeroxed and forwarded to VR counselor
Send back to Referring Unit
V.R. Counselor Interviews client
Client Rejects
Client Accepts
Joint-Conference Team Evaluates for Rehabilitative goals and services
Assignment to Special VR Dept. DPW Worker and Community Aide Project Team

WELFARE – REHABILITATION COOPERATIVE PLAN


Family Head Becomes AFDC Recipient
Case Review-Acceptance for Diagnosis
VR Interview Counseling Research Ratings
Begin Pre-vocational Evaluation
Psychological Testing Reports
Weekly Progress Reports Each Friday
Preliminary Medical Evaluation
Medical Consultant Ser. Research Ratings
Psychiatric Diagnosis if Indicated
Complete Pre-voc Eval-Adj Research Ratings
AFDC Screening Action for Project
Referral to Project
Family Review and Research Ratings
Preliminary Social Plan Formulation
Specialized Medical Diagnosis if Indicated
Voc Counseling Implemented Monitored Voc Plan
Pre-plan Vocational Counseling Completed
Team Coordination Info-Resources Effort
Voc-Social Plan Completed
Team Coordination Info-Resources Effort
Acceptance for Full Project Services
First Formal Staff Review
Second Formal Staff Review
Social Work-Implemented Monitored Social Plan
Pre-plan Social Work Completed
Screen-Out if Indicated-Complete Fed. Form
Team Coordination Info-Resources Effort
Assistance Denial or Adj Monitored Social Plan
Revise Plan if Indicated-Implement
Client Employment
Team Coordination Info-Resources Effort
Third Formal Staff Review
CLOSURE
Screen-Out if Indicated-
Monitored Vocational Activity

IV. Client Evaluation (Joint Pre-Planning)

A. Goals (general); example, competitive employment, homemaker, sheltered employment, etc.

B. Objectives (specific)

C. Assets

D. Liabilities

E. Needs: (to accomplish goals, objectives, and remove or reduce liabilities)

F. Resources

G. Opportunities

V. Specific Evaluations

A. Medical Evaluation

1. Purposes of medical evaluation = when will a medical exam be used, by whom and for what purpose

a. Establish nature and extent and prognosis of impairment
b. Assess client total health with its work implications
c. Ascertain if physical restoration can remove or minimize the impairment

2. Preparation of client for medical examination (joint DVR-DPW Medical Form)

a. Reasons examination needed
b. What may be done
c. Confidentiality of information obtained
d. Under what circumstances is medical information used by each agency

3. The importance of a medical history

a. Necessity for a precise and rather detailed recording of exactly how the impairment handicaps the client, particularly in his last job
b. How the counselor or social service worker obtains a medical history

(1) Avoidance of leading questions
(2) Tentative identification of clues of abnormality that call for additional questioning by the examining physician

4. Choice of general medical examining physician

   a. Advantages of using the client's personal physician
   b. Agency requirement that an adequate exam be done - an evaluation of the client, not just a certification of impairment
   c. Process of selecting a physician when personal physician not available

      (1) Need to explain agency needs to physician

         (a) Possible use of district medical consultant for this

5. Counselor and social service worker communication with examining physician

   a. Arrange appointment with notification of scheduled appointment to the other professional, agency
   b. Supply him with all existing medical information including your medical history
   c. Specifically request evaluation of clues of disease uncovered in medical history
   d. Specifically request answers to any medical questions worker has, i.e., communicate your medical informational needs about this client

6. Identify and obtain existing medical information regarding a client by utilizing:

   a. Hospital records - what do they contain, how do you get these reports
   b. What physician, x-ray, lab, hospital records to request

      (1) Client release of medical information
      (2) Any other medical information known to caseworkers

   c. When will existing medical data be a sufficient substitute to dispense with a new medical examination

      (1) Recency of previous examination
      (2) Quality of previous examination
      (3) Completeness of previous examination
      (4) Stability of the impairment
      (5) Age of client
      (6) Advice of the medical consultant
      (7) Counselor-elicited interval medical history

7. Joint-staff sharing of medical information with accompanying interpretation when requested

   a. Clarify if needed
   b. What items warrant request for completion if omitted
   c. Necessity to follow through on medical recommendations, or record reason for not doing so, or seek advice of district medical consultant
   d. Laboratory reports - routine and special

8. Indications for additional medical information

   a. Where information is insufficient to determine eligibility
   b. Recommendations of previous medical examiners
   c. Conflicting medical opinion or advice
   d. Severe client anxiety possibly amenable to effect of a reinforcing medical opinion
   e. District medical consultant requires
   f. History, physical, or lab findings not explained or adequately evaluated
   g. Certain major disease entities
   h. Question of conflict of interests by examining physician who proposes to give the client treatment

9. Choice of specialty consultant examiners

   a. American Board Certfied - meaning

      (1) Board eligible
      (2) Self-declared specialists

   b. Medical school or university hospital staff appointment
   c. Patient choice, referring physician choice, examining physician choice - how much weight to give
   d. Need for integrated advice of more than one specialty examiner or complicated group practice consultants (clinic, university hospital, etc.)
   e. Special clinics - amputee, seizure, potical aid, cardiac work classification units
   f. Advice of district medical consultant

10. Supply a copy of all relevant medical data available to examining specialists

11. Establish procedure for interpreting medical data to clients

12. Provide hospitalization for diagnostic purposes where recommended or deemed necessary

3. Psychological evaluation

1. Meaning of psychological evaluation and assessment

a. Represents a systematic attempt to construct a working psychological "image" or "model" of the client
b. A set of hypothesis used for making decisions, predictions, explanations, and descriptions about individual behavior in natural living situations

2. Some basic areas covered in psychological assessment

Individual's intellectual capacity, motivations, conflicts, ego defenses, environmental and self-evaluations, interests, and aptitudes, and general personality organization

3. Psychological assessment procedures

a. Observation of general behavior
b. Interviewing
c. Psychological tests

(1) Intelligence tests
(2) Personality tests

(a) Nonprojective
(b) Projective

(3) Other diagnostic tests

4. Need for psychological assesstment

a. Needed when

(1) Client manifests behavioral disorders
(2) Long-term or expensive training is involved in a rehabilitation plan
(3) Mental retardation has to be determined (legal requirement)
(4) Client or worker need information or confirmation of the client's abilities, aptitudes, achievements, interests, and personality patterns
(5) Data on the client's capacities and abilities are lacking, ambiguous or contradictory
(6) Important talents, capacities, abilities, or disabilities are suspected by the worker or client
(7) An individual is known or suspected to have certain disabilities that require specialized evaluations of his capacities, abilities, skills, interests and personality

b. Not necessarily required when

(1) Client has recently been successfully employed and intends to return to his work following physical restoration services
(2) Client has been successfully employed but is now unable to find similar work because of employer prejudice toward the handicapped
(3) Client has been successfully employed and only a minimum shift is contemplated in the type of work that he will be doing in the future
(4) Client has a long and rich background of information on jobs held and they are in related types of work
(5) Client has a long and rich background of educational information and client plans to study or work in areas related to his background
(6) The individual is not cooperative and does not desire to be tested

5. Reasons for the use of tests

a. As an aid in counseling

(1) Client can better understand himself
(2) Aids in making reasonable plans and decisions
(3) Helps client to identify problem areas

b. As a diagnostic instrument - usually essential in a case study
c. Provides opportunity for observation in a psychological situation and an opportunity to obtain information not otherwise available
d. Useful in relation to other services

(1) Medicine - how will the client accept treatment
(2) Training - aptitudes and limitations
(3) Placement - are client's attitudes and adjustment such as to create placement problems

e. Can save agency money and time and provide better answers to client problems

6. The psychological report

a. Basic identifying data
b. The reason for referral
c. Behavioral observations
d. Tests administered
e. Intellectual functioning
f. Personality description and dynamics
g. Diagnostic impressions and prognosis
h. Recommendations for treatment or disposition

7. Limitations of psychological testing

   a. Tests results depend on the attitude of the person taking the test
   b. The value of testing depends on the competence of the interpreter
   c. There is a danger that the psychologist and the worker may become overly dependent on tests
   d. Tests are not always appropriate for individuals with special defects or difficulties
   e. Tests may put too much emphasis on the individual tested and so overlook the importance of his life situations
   f. All test interpretation is related to probability

8. Role of the psychologist and the psychiatrist

9. The worker's role in determining need and extent of psychological evaluation

10. Preparing the client for the psychological evaluation

    a. Determine client's attitudes toward psychological examinations
    b. Correct misinformation and modify unwholesome attitudes
    c. Obtain client's consent
    d. Give client full and accurate information about the appointment

11. Use existing psychological data

    a. Employment service
    b. Public school
    c. Vocational education
    d. Private psychologists
    e. Other private and public agencies, i.e., mental health clinics

12. Workshop on Psychological and Vocational Evaluation

    a. Psychological Evaluation

       (1) Role of the Psychologists in Rehabilitation and Welfare
       (2) Standards for Psychological Evaluations
       (3) Content of a Psychological Evaluation
       (4) Psychometric Terminology
       (5) The use of Psychological Testing with Handicapped Individuals
       (6) Clinical Psychological Tests

           (a) Minnesota Multiphasic Personality Inventory
           (b) Sixteen Personality Factor Questionnaire
           (c) Slosson Intelligence Test
           (d) Peabody Picture Vocabulary Test

(e) Wechsler Adult Intelligence Test
(f) Bender Motor Gestalt Test
(g) House-Tree-Person Test
(h) Rorschach Ink-blots
(i) Thematic Apperception Test

(7) Psychometric Assessment of Vocational Potential

(a) Kuder Preference Record
(b) Differential Aptitude Test
(c) Minnesota Paper Form Board Test
(d) Wide Range Achievement Test
(e) Minnesota Interest Inventory
(f) General Aptitude Test Battery
(g) N A T B Verbal Aptitude Test Battery

C. Vocational Evaluation

1. Meaning of vocational evaluation

a. It represents a process of gathering, interpreting, analyzing, and synthesizing vocationally significant data regarding an individual and relating it to occupational requirements and opportunities
b. It seeks to determine the client's vocational assets and limitations and places them in a frame of reference which will assist the client in arriving at realistic vocational goals

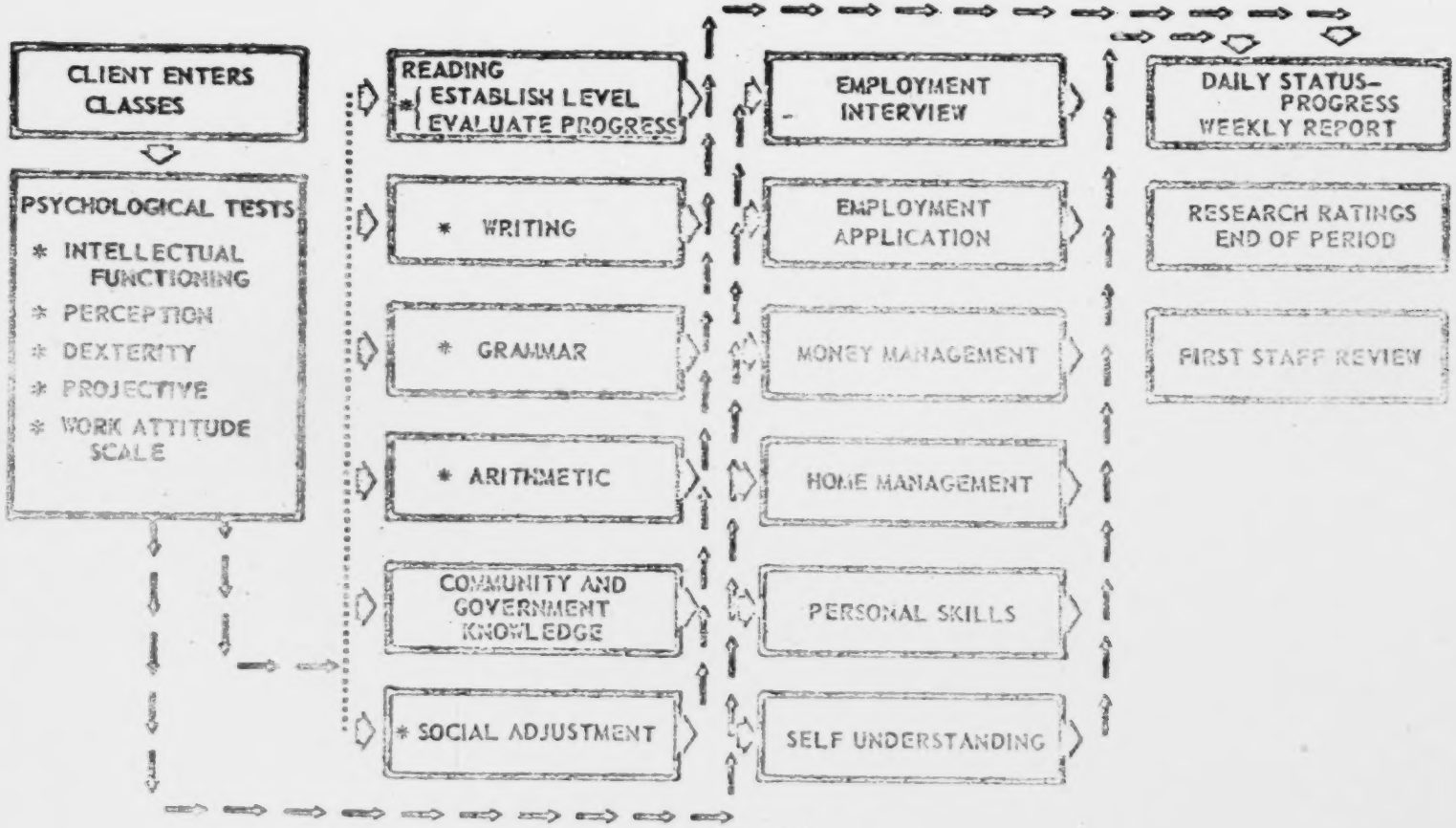
2. General topic areas in vocational assessment

a. Aptitudes, skills, work habits, attitudes, interests, goals, motivations, and hobbies

3. Vocational evaluation methodology

a. Referral sources
b. Interviewing

Pre-vocational Diagnostic Evaluation-adjustment



(1) Client
(2) Family
(3) Employers

c. Survey of work history, i.e., employment records

(1) Name, address, and kind of business of all employers
(2) Specific jobs held by the client
(3) Duration of each job
(4) Wages earned

d. Paper - pencil vocational testing

(1) Interest
(2) Aptitudes
(3) Vocational test report

(a) Basic identifying data
(b) Reason for referral
(c) Orientation - history and present functioning
(d) Tests used
(e) Behavioral observations
(f) Interest testing
(g) Aptitude testing
(h) Summary and recommendations

e. Extended vocational appraisal

(1) Work evaluation and job samples
(2) Pre-vocational evaluation
(3) Job tryouts

4. Counselor's role in vocational assessment

a. Assessing clients work experience

(1) Level of skills as evidenced by job interests, attitudes, degrees of responsibility assumed, advancements and aspiration
(2) Client work habits
(3) Relation of job experience to onset of disability
(4) Vocational or training background
(5) Employment relationships

(a) Supervisor
(b) Associates

(6) Vocational Interests

(a) Demonstrated
(b) Expressed

(7) Evaluate gaps in employment

b. Assessing clients without work experience

(1) Vocational interests

(a) Demonstrated
(b) Expressed

(2) Vocational goals
(3) Vocational training potential
(4) Educational potential
(5) Work-oriented activities
(6) School performance, relationships with peers, adults, etc.

5. Vocational variables to be considered in determining vocational objective

a. Insufficient understanding of capacities and interests
b. Provide adequate occupational information
c. Selection of job objectives in line with abilities and interests
d. Choice of and arrangement for course of training
e. Location of and adjustment to a job
f. Client's acceptance of and interest in vocational goal

6. Maintaining case recording standards for the vocational evaluation

a. Counselor documentation of work history

Kinds of jobs, duration of major employment, and employer - employee relations

b. Documentation of vocational training

Source, type, duration, and level of skills achieved

c. Documentation of vocational appraisal

Vocational interests, aptitude, dexterity, and results of formal evaluation procedures

d. Evidence of client's level of vocational goals, leisure time activities, and aspirations

e. Evidence that vocational training is needed or not needed to help client achieve vocational goals

D. Educational evaluation

1. The findings of the counselor will be conditioned by the level of education already achieved by the client at point of referral. For our purpose, the educational evaluation is limited to the cultural area designated as general education. Vocational education and trades training are considered in the vocational evaluation section.

a. Importance

(1) Contributing factor in determining the social adaptability of client
(2) Contributing factor in determining personal study habits of clients
(3) Contributing factor in determining the work potential of client

b. Methodology

(1) Securing information from school records and school authorities
(2) Collaboration with school guidance personnel in study and guidance of client in advance of graduation or termination of academic training
(3) Client interviews
(4) Interviews with family, others
(5) Administration of educational achievement and aptitudes tests

c. Each agencies need for educational information - depth of development depends upon individual client's needs

d. Counselor caseworker considerstions

(1) Learning capacity of the client has been ascertained
(2) Consistent documented picture of the achievement level
(3) Breadth and variety of the extra-curricular activity is known
(4) Client's study habits and motivation for study is known
(5) Achievement compared to educational potential is clear
(6) Academic subject preferences are expressed and verified
(7) Emotional reaction to situations of stress in educational endeavors
(8) Social skills manifested in the educational environment are appraised and evaluated

e. Other considerations

(1) Educational evaluation should be related to vocational potential
(2) Educational evaluation should be thorough enough to demonstrate consideration by the counselor
(3) Educational evaluation takes on greater significance with

(a) Younger disabled persons
(b) Clients desiring pursuit of higher education
(c) Clients who may enter trades or technical areas requiring minimum levels of academic proficiency

E. Social Evaluation

1. Importance

Social evaluation involves the securing, evaluation, and recording of those pertinent factors, personal and impersonal, in the disabled individual's functioning which may be assets or liabilities with respect to desirable accomplishments of his total rehabilitation. These social factors cannot be simply separated out, but must be related to all other knowledge about the client to make them significant and meaningful as related to all other data. This evaluation of social factors enables the couselor to understand how the client perceives of himself in relationships with his family, his community, or other social segments.

2. Purpose

Social evaluation provides information which, in context with client's behavior, values and goals, gives the counselor a background against which client's problems can be more clearly discerned.

3. Scope of the social evaluation

Social evaluation to be adequate should

a. Provide data against which client problems can be more clearly identified and appraised
b. Identify the type of problem

(1) Personality and character
(2) Family and environmental

c. Identify client's strengths
d. Be comprehensive enough to provide the basis upon which competent professional judgments can be made

4. Methodology

The client interview is the prime method of obtaining social information along with observing and documenting significant reactions during interview. Essential information pertaining to a client's perception of himself and his relationships to his total environment is outlined below. Collateral sources should be utilized to implement and clarify information obtained during interviews.

5. Client's history and present situation

a. Attitudes towards:

(1) Disability
(2) Agency and Counselor
(3) Employment

b. Motivations such as

(1) Why does he come to agency
(2) Employment

c. Flexibility and/or adaptability

(1) Can or will client change localities or mode of life if this appears necessary for his ultimate rehabilitation
(2) Ability to communicate (physical and language)
(3) Personal appearance

d. Family

(1) Determine such factors as:

(a) His place in the family (or with other household members)
(b) Has handicap made client unduly dependent
(c) Has dependency been increased by attitude of family toward disabled client
(d) Economic level (has client continued in supporting role or dependency role)
(e) Does family regard handicap of member as a blight on their social standing or image in community
(f) Aspirations of family for client and for family itself
(g) Family adjustments caused by client's disability

e. Community

Determine such factors as:

(1) How does client identify with community
(2) Areas of activity participation
(3) Community attitude toward disability
(4) Employer and/or peer influences
(5) Size and kind of community
(6) Acceptance of client and family in community before and after disability
(7) Characteristics of immediate neighborhood

VI. Delivery of Service System (referral to Follow-up)

A. Inservice Training

1. For Screening and Referral, policy and procedures

(a) Special staffing arrangements explained
(b) Procedures reviewed
(c) Lines and methods of communicating this

B. Service Delivery

1. Process

(a) Agency coordinator
(b) Purchase of Services
(c) Service by subcontract

2. Staff Responsibilities

(a) Screening

The screening of applicants for this program should be made according to the screening criteria for evaluating vocational rehabilitation potential by the caseworker and/or counselor. The persons receiving the highest score on the screening criteria does not necessarily need to be the persons selected. Priority of referrals should depend on the medical evaluations and the client's readiness to enter the program.

Eligible persons already on VR and DFW roles may be transferred into this program.

Potentially eligible persons may apply direct or may be referred by interested persons or agencies (public or private) on behalf of the applicant.

(b) Referral from Department of Welfare

(c) Referral from Vocational Rehabilitation

(d) Refusal of client to accept services

(e) Refusal of client to accept suitable employment and termination

(f) Resources to be jointly developed and used; e.g., public relations, literature, medical, job placement, training, aides, etc.

C. The Rehabilitation Process (DVR Agency)

1. Case Finding, Selection, and Investigation

2. Client Study Data

   (a) Medical Evaluation
   (b) Psychological Evaluation
   (c) Vocational Evaluation
   (d) Educational Evaluation
   (e) Cultural/Social Evaluation

3. Rehabilitation Diagnosis

   (a) Determination of Eligibility
   (b) Certification of Eligibility
   (c) Identification of Problems
   (d) Identification of Rehabilitation Services
   (e) Vocational Appraisal for Purpose of a Job Objective

4. Planning and Provision of Rehabilitation Services

   (a) Activation of the Rehabilitation Client Plan
   (b) Utilization of Client's Financial Resources
   (c) Justification of Rehabilitation Services
   (d) Provision of Services
   (e) Description of Services

      (1) Physical Restoration Service
      (2) Training
      (3) Maintenance
      (4) Transportation
      (5) Placement
      (6) Tools, Equipment, Initial Stocks, and Supplies
      (7) Occupational Licenses
      (8) Small Business Enterprises
      (9) Other goods and Services

   (f) Utilization of Community Resources

5. Placement and Follow-up

   (a) Location of Job Opportunities
   (b) Arranging and Planning for the Employer Interview
   (c) Presenting the Client
   (d) Job Analysis
   (e) Job Engineering
   (f) Utilization of Public and Private Employment Agencies
   (g) Follow-up and Evaluation of Placement
   (h) Case Closure

D. The Social Service Process (DPW Agency)

1. Case Work

2. Group Work

3. Community Organization

4.

5.

6.

VII. Approaches to Understanding and Motivation

A. Defining the Client

1. Client Characteristics

(a) Personal Characteristics
(b) Family Life Characteristics
(c) Relationships with others in community

2. The Rural Appalachian Subculture

3. The Urban Ghetto Subculture

4. Communication Regarding Differing Life Styles of client, worker, and employer

B. Understanding and developing positive attitudes of staff toward public welfare recipients

1. Dispelling by giving statistical information

2. Understanding cultural factors affecting rehabilitation; i.e., social, economic, and physical which include education, housing, job opportunities, psychological phenomena as well as acute and chronic illnesses.

3. Counselors and case workers need to be sensitive and aware of the special problems and needs of public assistance recipients. Characteristics and problems of disabled clients which may include the following:

   (a) Fear of losing welfare payment
   (b) Sense of hopelessness and despair
   (c) Coupling of disability with lack of skill and little education
   (d) Dependency
   (e) Passivity or aggressiveness
   (f) Family attitudes affecting rehabilitation
   (g) Inadequate income
   (h) Lack of a good child care plan
   (i) Poor use of existing resources and fear of rejection

   Films: "Unmet Needs of Special Groups" and "The Captive"

C. Attitudes of Clients

   1. Helping staff to understand reasons for resistance to specific services

   2. Understanding cultural factors affecting rehabilitation

D. Understanding of the special problems and needs of clients and promote techniques to work effectively with the public assistance recipient such as:

   1. Intensive casework

   2. Supportive Counseling

   3. Frequent person-to-person involvement

   4. Individual planning and provision of services to overcome barriers

E. Innovative Modalities for Service

   1. Group Work

   2. Case work with families

   3. Community Organization

MYTHS VS. FACTS

MYTH 1: Welfare families are loaded with kids - and have more just to get more money.

FACT: Typical welfare family has mother and three children. Trend toward smaller families on welfare. Birthrate, since 1967, dropping.

MYTH 2: Most welfare families are black.

FACT: Largest racial group - 49 per cent - is white. Blacks represent 46 per cent.

MYTH 3: Why work when you can live it up on welfare?

FACT: Average payment for family of four varies from a low $60 per month to a high of $375 per month.

MYTH 4: Most welfare children are illegitimate.

FACT: Sizeable majority (68 per cent) were born in wedlock.

MYTH 5: Once on welfare always on welfare.

FACT: Average family on rolls for 23 months.

MYTH 6: Welfare people are cheats.

FACT: Fraud occurs in less than four-tenths of one percent of total caseload.

MYTH 7: Give them more money and they'll spend it on drink and big cars.

FACT: Most families report that extra money would go for essentials.

MYTH 8: Welfare's just a dole, a money handout.

FACT: SRS reports many other ancillary services such as medicaid (55.7%), employment counseling (54.2%), child support (37.5%), et.al.

MYTH 9: Welfare rolls are full of able-bodied loafers!

FACT: Less than one percent of welfare recipients are able-bodied, unemployed males.

F. Understanding Implications of Illnesses and Disabilities

1. Emotional Problems

2. Behavioral Disorders

3. Selected Disabilities

VIII. Continuing the Team Approach in the use of Community Resources

A. Welfare Rights Organization

B. Civic Organization

C. Organized Labor

D. Service Club

E. Agencies involved with disabled (e.g., WIN Program, Adult Education, Health Dept., Medical Assistance, et. al.)

F. Consumer Advocacy and Civic Groups

The success of projects depends in large measure on the understanding and support of the local community and the key influential organizations within the community. The local chapter of the Welfare Rights Organization may be one of the organizations. The project coordinator and the staff involved with inservice training should meet with the leadership of the organizations and work with them on the preparation of an in-service training package to be presented to project staff. The package may include the need for the organizations, their goals and their advocacy roles. Members of the organizations should have opportunity to discuss matters of common concern with project staff. Common goals may be identified so that advocacy organizations and project staff can work together cooperatively. The same strategy should apply to civic clubs and labor organizations, members of consumer advocacy groups.

G. Rehabilitation Facilities and Workshop

1. Types of Facilities and Workshops

2. Relationship between Public Welfare, Vocational Rehabilitation and Facilities

3. Types of Services Provided

4. Developing a Community Facility

5. Funding and Grant Programs

H. Legal Aid

IX. Feedback System Between Cooperating Agencies

A. Referral

(1) Accepted

(2) Rejected

B. Joint Planning

C. Completion of Individual Services for Client

(1) Physical restoration

(2) Evaluation

(3) Training

(4) Placement

(5) Follow-up

(6) Closure

X. POSSIBLE RESOURCE AIDS FOR UNITS

1. Social System Analysis (an example of one model to help understand problems of motivation within social systems), Reuben J. Margolin, Ed. D.*

   Purpose =

   The purpose of this unit is to understand the problems of motivation through the use of a social system model for examination and evaluation of case material. (Seven pages mimeographed) Focused on four areas = systems, roles, pressures, and future action.

   *Associate Professor, Social Science, Department of Community Service, Center for Continuing Education, and Project Director, New England Rehabilitation Research Institute, Northeastern University, Boston, Massachusetts.

2. Perceptions (one approach to the understanding of motivation), Paul E. Eiserer, Ph. D., Department of Psychological Foundations and Services, Teachers College, Columbia University, New York City, N. Y.

   A perceptual approach to the understanding of motivation. By being empathic and sensitive, workers attempt access to private world of others, so as to receive a clearer VIEW about the client's ways of perceiving, which form bases for his actions.- 2 pages mimeographed.

3. An Understanding of Problems of Motivation Through An Evaluation of Case Material (selected case summaries).

   Purpose =

   To seek an understanding of problems of motivation in a client - worker relationship through an evaluation of case material - Moderator's Guide inclosed. Such areas as follows to be discussed =

   (a) Perceptions, attitudes, and goals of the client
   (b) Perceptions, attitudes, and goals of the workers
   (c) Pressures operating upon the client and worker
   (d) Similiarities and differences between client goals and worker goals. (Seven pages mimeographed)

4. Response Exercise and Discussion (an effort to look at counselor attitudes in dealing with client attitudes). 18 pages mimeographed.

   (a) Rehabilitation Counseling Response Test - C. H. Patterson, University of Illinois, Champaign, Illinois

   (b) Scoring and Discussion of RCRE.

   Five different attitudes are measured as follows: evaluative, interpretive, supportive, probing and understanding. Responses are not necessarily right or wrong, but represent differing approaches to the client and counseling. Scoring provides a profile of preferences for the differing approaches.

5. Selected Readings

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PREPARED BY: Regional Counselor Training Center
Charleston, West Virginia
November, 1971

C. Collateral Readings

COLLATERAL READING

A. COUNSELING: THEORY AND PRACTICE

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On Becoming a Person, Rogers. Houghton Mifflin Co.

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An Orientation to Chronic Disease and Disability, Myers. The MacMillan Co.

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A Survey of Medicine & Medical Practice for the Rehabilitation Counselor, Felton. U. S. Government Printing

C. THE NATURE OF REHABILITATION

A History of Vocational Rehabilitation in America, Obermann. Denison

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C. THE NATURE OF REHABILITATION (Continued)

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D. PSYCHOLOGICAL AND VOCATIONAL EVALUATION

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F. MENTAL RETARDATION

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Occupational Information for the Mentally Retarded, Stahlecker. Thomas

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G. HEARING DISABILITIES

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H. VISUAL HANDICAPS

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I. PSYCHOLOGY AND SOCIOLOGY (Continued)

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The Revolution of Hope: Toward a Humanized Technology, Fromm. Harper and Row

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Toward a Psychology of Being, Maslow. D. Van Nastrand Co., Inc.

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NOTE: For further information related to author's full name, cost of text, publisher's address, etc., consult the following references: (1) Books in Print, U.S.A. Vol I & II with Addendum. R. R. Bowker Co., 1968 and (2) Subject Guide to Books in Print, Vol. I & II, R. R. Bowker Co., 1969.

7. FILM ABSTRACTS

THE CAPTIVE - Distributed by: Film Library, West Virginia University, Morgantown, West Virginia, 26506. Deals with the effects of unemployment on a coal miner and his family. The setting is Rural Southern Appalachia. Length of film: 25 minutes - Black and White.

THE COMPREHENSIVE PHYSICAL EXAMINATION - Distributed by: Social & Rehabilitation Service, Washington, D. C. Filmstrip and Tape. Emphasizes techniques and methodology of thorough physical examination. Length of Film Strip and Tape: 20 minutes - Color.

DEHUMANIZATION AND THE TOTAL INSTITUTION - Distributed by: Medical Services Division, Minnesota Department of Public Health Works, Centennial Building, St. Paul, Minnesota. An animated film that explores the dehumanizing practices that Institutional living may have on the emotionally disturbed. Length of Film: 15 minutes - Color.

THE FULL CIRCLE - Distributed by: International Film Bureau, Chicago, Illinois Demonstrates the Rehabilitation of an emotionally disturbed commercial artist. Th following mental health treatment methods are included: Group Vocational Counseling; the Community Mental Health Facility; Vocational Rehabilitation Services, and The Team Approach. Length of Film: 35 minutes - Black and White.

THE GAP - Distributed by: Social and Rehabilitation Services, Washington, D. C. This film explores the need for improved delivery of Rehabilitation Services. The film includes several examples of innovations in delivering rehabilita ion services. Length of Film: 27 minutes - Color.

FILM ABSTRACTS (con'td)

THE HOPE AND THE PROMISE - Distributed by: Carol Ramsey Productions, New Orleans. Three clients rehabilitations are portrayed in an attempt to demonstrate the various disability groups served by Vocational Rehabilitation. The clients have these disabilities: Emotional Disturbance, Mental Retardation, and Arthritis. Length of Film: 29 minutes - Color.

THE INNER WORLD OF APHASIA - Distributed by: Edward Feil Productions, 1514 Prospect Avenue, Cleveland, Ohio, 44115. Deals with psychological, perceptual, and family problems of the person who has aphasia following a stroke or brain injury. Attempts to portray inner-thought processes of the aphasic individual. Length of Film: 20 minutes Color.

THE MASK - Distributed by: U. S. Public Health Service, Communicable Disease Center, Atlanta Georgia, 30333. Deals with the concept that alcoholism is a disease not a crime. Alerts police and others that alcohol maymask symptoms of both physical and mental disorders. Length of Film: 33 minutes - Black and White.

MASLOW AND SELF-ACTUALIZATION - Distributed by: Psychological Films, 205 West 20th Street, Santa Ana, California, 92706. A two film series that features Dr. Abraham Maslow discussing the dimensions of self-actualization and elaborates on recent Research & Theory related to each dimension.

FILM #1 - Topics Discussed:

HONESTY	AWARENESS
1) Sense of Humor	1) Efficient Perception
2) Social Interest	2) Freshness of Appreciative
3) Love	3) Peak Experience
	4) Ethical Awareness

Length of Film: 30 minutes - Color.

FILM ABSTRACTS (con'td)

MASLOW AND SELF-ACTUALIZATION (Con'td)

	FREEDOM	TRUST
FILM #2 - Topics Discussed:	1) Retachment	1) Life Mission
	2) Creativeness	2) Autonomy
	3) Spontaneity	3) Acceptance

Length of Film: 30 minutes - Color.

MODERN CONCEPTS OF EPILEPSY - Distributed by: Ayerst Laboratories, 685 3rd. Avenue, New York, New York 10017. Describes various types of seizures, problems, treatment modalities, prognosis, and need for teamwork approach. Length of Film: 30 minutes - Color.

NEED FOR DECISION - Distributed by: Union Carbide Corporation, South Charleston, West Virginia. Depicts the importance of the employer to provide the alcoholic employee with the necessary information as to where to go for assistance with his drinking problem. Length of Film: 20 minutes - Black and White.

THE ODDS AGAINST - Distributed by: American Foundation, Institute of Corrections, Philadelphia National Bank Building, Philadelphia, Pennsylvania, 19107. Focuses on one Public Offender. Explores the correctional system: detention, probation, imprisonment, and parole. Contrasts the older institutions and up-to-date facilities and programs. Length of Film: 30 minutes - Black and White.

OUT OF ORBIT - Distributed by: The Jam Handy Organization, 2821 E. Grand Boulevard, Detroit 11, Michigan. Deals with the impact of Alcoholism on the family unit. Length of Film: 25 minutes - Color.

FILM ABSTRACTS (con'td)

THE PORTRAIT OF AN INTERNIST - Distributed by: The Film Library, Operations Center, 43 West 61st. Street, New York, New York, 10023. Emphasizes the stress placed on an Internist to make an accurate diagnosis. Also demonstrates a general physical examination. Length of Film: 25 minutes - Color.

REINFORCEMENT THERAPY - Distributed by: Smith, Kline, and French, 1500 Spring Garden Street, Philadelphia, Pennsylvania, 19101. Demonstrates the use of Behavior Modification Principals with three groups of individuals; profoundly emotionally disturbed children; the mentally retarded in a educational setting; and chronic psychotic hospitalized patients. Length of film: 35 minutes - Black and White.

THE REVOLVING DOOR - Distributed by: American Foundation, Institute of Corrections, Philadelphia National Bank Building, Philadelphia, Pennsylvania 19107. Deals with the petty offender and the inadequacies of the present jail system. Follows the misdemeanant through the trial system of lower courts into the local lock-up. The film reviews progressive programs recently established in various jail systems. Length of Film: 31 minutes - Black and White.

SEARCH AND RESEARCH: PSYCHOLOGY IN PERSPECTIVE - Distributed by: Psychological Films, 205 West Twentieth Street, Santa Ana, California 92706. An overview film on the field of counseling psychology. Through the medium of a story of a young lady who seeks psychotherapy, the film attempts to describe the three forces of counseling psychology:

FILM ABSTRACTS (con'td)

SEARCH AND RESEARCH: PSYCHOLOGY IN PERSPECTIVE (Con'td)

experimental, psychoanalytic, and existential or humanistic psychology. The film provides interviews with Dr. Harry Harlow, Dr. Rollo May, and Dr. Carl Rogers. Length of Film: 30 minutes - Black and White.

SUPERVISION IN VOCATIONAL REHABILITATION COUNSELING - Distributed by: Campus Films, 20 E. 46th Street, New York 10017. Portrays how a counselor supervisor interacts with three counselor-trainees during their clinical practicum. The counselor-trainees are also shown counseling with clients assigned to them. Length of Film: 55 minutes - Color.

THREE APPROACHES TO PSYCHOTHERAPY - Distributed by: Psychological Films, 205 West South Street, Santa Ana, California 92705. A three film series:

FILM #1 - Dr. Carl Rogers: General Introductions to Film Series; Description of Client-Centered Therapy; Interview with patient - "Gloria"; Summation of Effectiveness of interview.

Length of Film: 48 minutes - Black and White.

FILM #2 - Dr. Fredrick Perls: Description of Gestalt Therapy; Interview by Dr. Perls with patient - "Gloria"; Summation of effectiveness of interview.

Length of Film: 32 minutes - Black and White.

FILM #3 - Dr. Albert Ellis: Description of Rational-Emotive Psychotherapy; Interview by Dr. Ellis with patient - "Gloria";

FILM ABSTRACTS (Con'td)

THREE APPROACHES TO PSYCHOTHERAPY (Con'td)

Summation of effectiveness of interview; Evaluation by patient of her experience with the three therapists.

Length of film: 37 minutes - Black and White.

TO LIVE AGAIN - Distributed by: West Virginia Division of Vocational Rehabilitation, Charleston, West Virginia. Emphasizes the need and utilization of the various disciplines found in the comprehensive Rehabilitation Center. Clearly demonstrates the functional components of bracing, wheelchair prescription, occupational and physical therapy.

Length of Film: 45 minutes - Color.

TO YOUR HEALTH - Distributed by: Mask Communications, Columbia University Press, 1125 Amsterdam Avenue, New York 25, New York. An animated film that gives an overview of the effects of alcohol on the body and the nature of alcoholism. Length of Film: 18 minutes - Color.

UNMET NEEDS OF SPECIAL GROUPS - Distributed by: Social and Rehabilitation Services, Washington, D. C. A five film series that deals with providing Rehabilitation Services to the following disability groups:

FILM #1 - A Stroke Victim

FILM #2 - A Man in Need of Mental Health

FILM #3 - Men and Women Learning Esophageal Speech

FILM #4 - Teenage Drug Addicts

FILM #5 - Disadvantage of Families with Children Living in Urban Ghettos and Rural Isolation.

Length of each film: 15 minutes each - Color.

FIIM ABSTRACTS (Con'td)

VOCATIONAL REHABILITATION IN A COMMUNITY HOSPITAL - Distributed by: The Arthritis Foundation, Inc., 221 Park Avenue, South, New York, New York 10003. Demonstrates the advantages of providing Vocational Rehabilitation within existing hospital facilities. The comprehensive step-by-step process of actual clients is depicted. Length of Film: 35 minutes - Color & Black & White

WILL IT BE YOU - Distributed by: Holland-Wegman Productions, Inc., 207 Delaware Avenue, Buffalo, New York. Emphasizes Vocational Rehabilitation Counseling as a career. Explains the function of Rehabilitation Counseling and the various settings that counselors are employed in. Length of Film: 20 minutes - Color.

THE WORK OF THE BLOOD - Distributed by: Encyclopedia Britannica Education Corp., Rental Library, 4424 Oakton Street, Skokie, Illinois 60076. Defines the function of blood, its normal function and its dyscrasias. Depicts the diagnostic uses of blood, composition of blood, and blood problems (e g.) anemias, hemophilia, leukemias, etc. Length of Film: 20 minutes. - Color

8. SAMPLE AGENDA

OVERCOMING BARRIERS TO REHABILITATION OF

THE DISABLED/DISADVANTAGED WELFARE

RECIPIENT AND APPLICANT

SPONSORED JOINTLY BY

Region III, Regional Counselor Training Program

Charleston, West Virginia

and

West Virginia Division of Vocational Rehabilitation

and

West Virginia Department of Welfare

and

West Virginia University

1st Session: North Bend State Park
Cairo, West Virginia

September 12 - September 15, 1972
(8:00 p.m. Tuesday - 12 Noon Friday)

2nd Session: Twin Falls State Park
Mullens, West Virginia

September 19 - September 22, 1972
(8:00 p.m. Tuesday - 12 Noon Friday)

Program Co-Chairman: Warren O. Harry
H. T. Lyttleton
William R. Phelps
Jack Reno

AGENDA

TUESDAY

6:00 p.m. - 8:00 p.m.	PRE-REGISTRATION
8:00 p.m. - 10:00 p.m.	Social Hour and Get Together

WEDNESDAY

8:30 a.m. - 9:00 a.m.	FINAL REGISTRATION AND COFFEE
9:00 a.m. - 9:45 a.m.	Welcome and Introduction (SEMINAR OPENING) 1. H. T. Lyttleton, Rehabilitation 2. Warren O. Harry, Welfare 3. William R. Phelps, Regional Counselor Training Center
9:45 a.m. - 10:00 a.m.	Coffee Break
10:00 a.m. - 12:00 noon	"Communications and Social Change" - William Carmack, Ph.D., University of Oklahoma
12:00 noon - 1:00 p.m.	LUNCH
1:00 p.m. - 2:30 p.m.	Small Groups Workshop Sessions - Observations and Reactions of Dr. Carmack's Presentation Group I - Dr. Robert Masson Group II - Dr. Daniel Rubinstein Group III - John Wade Group IV - Jack Reno
2:30 p.m. - 2:45 p.m.	Coffee Break
2:45 p.m. - 4:30 p.m.	Report from Groups Closing Remarks - Dr. Carmack
6:00 p.m. - 7:30 p.m.	Get Together (Open) Selective Film Showing 1. The Captive 2. The Gap

THURSDAY

8:30 a.m. - 9:30 a.m.	Panel Discussion - Case Studies - Present and Former Joint DVR-DPW Agency Clients (Successful Rehabilitation and Non-successful Rehabilitation) Moderator - John Wade
	Discussion
10:00 a.m. - 10:15 a.m.	Coffee Break

10:15 a.m. - 12:00 noon	"Theories and Practices of Group Work" - Emanuel Trepp, Virginia Commonwealth University
	Discussion
12:00 noon - 1:00 p.m.	LUNCH
1:00 p.m. - 2:30 p.m.	"Appalachian Culture" - O. Norman Simpkins, Ph.D., Marshall University
	Discussion
2:30 p.m. - 2:45 p.m.	Coffee Break
2:45 p.m. - 4:00 p.m.	Moderator - William R. Phelps "Internal and External Locus of Control," and "Attitudes of Professionals on Working with the Poor" - Alfred MacDonald, Ph.D., West Virginia University
	Discussion
6:00 p.m. - 7:30 p.m.	Get Together (Open) Selective Film Showing 3. Reinforcement Therapy (Behavior Modification) 4. Client-Centered Counseling VS Behavioral Counseling

FRIDAY

8:30 a.m. - 10:00 a.m.	Moderator - William R. Phelps "Behavior Modification Approaches" - Richard T. Walls, Ph.D., West Virginia University
	Discussion
10:00 a.m. - 10:15 a.m.	Coffee Break
10:15 a.m. - 11:15 a.m.	"Basics of Work Evaluation" - Men-Shu (Mike) Tseng, Ed.D., West Virginia University
	Discussion
11:15 a.m. - 11:30 a.m.	Summary and Recap - Moderators: Warren O. Harry and H. T. Lyttleton
11:30 a.m.	Expense Accounts - William R. Phelps
11:45 a.m.	Adjournment

LIST OF SPEAKERS AND FACULTY
(DVR-DPW Joint Training, West Virginia)

William Carmack, Ph.D.
University of Oklahoma
Norman, Oklahoma

*Warren O. Harry, Coordinator
Welfare and Rehabilitation Services
West Virginia Department of Welfare
Charleston, West Virginia

*H. T. Lyttleton, Coordinator
Rehabilitation-Welfare Services
West Virginia Division of Vocational Rehabilitation
Charleston, West Virginia

Ranjit Majumder, Ph.D., Director of Research
West Virginia University, Research & Training Center
Morgantown, West Virginia

Robert Masson, Ed.D.
Chairman, Department of Rehabilitation Counseling
West Virginia University
Morgantown, West Virginia

*William R. Phelps, Program Director
Regional Counselor Training Program
West Virginia Division of Vocational Rehabilitation
Charleston, West Virginia

*Jack Reno, Assistant Program Director
Regional Counselor Training Program
West Virginia Division of Vocational Rehabilitation
Charleston, West Virginia

Daniel Rubinstein, Ph.D.
Kanawha Valley Graduate Center
School of Social Work
Institute, West Virginia

Emanuel Tropp
Virginia Commonwealth University
School of Social Work
Richmond, Virginia

O. Norman Simpkins, Ph.D.
Chairman, Department of Sociology
Marshall University
Huntington, West Virginia

Men-Shu (Mike) Tseng, Ed.D., Associate Professor
West Virginia University, Research & Training Center
Morgantown, West Virginia

*John B. Wade, III, State Director
Rehabilitation Welfare Programs
Virginia Department of Vocational Rehabilitation
Richmond, Virginia

Richard T. Walls, Ph.D., Assistant Professor
West Virginia University, Research & Training Center
Morgantown, West Virginia

Alfred MacDonald, Ph.D.
West Virginia University
Morgantown, West Virginia

* Resource person for all groups.

9. (POSSIBLE TRAINING MODEL)

DEPARTMENT OF VOCATIONAL REHABILITATION TRAINING MODEL

GROUP: Counselors

LEVEL: Occupational

TOPIC: Case Finding

		Instructional Methods	Evaluation Methods
CONCEPTS AND KNOWLEDGE			
ATTITUDES			
SKILLS			

CASE FINDING

KNOWLEDGE

Every individual who is vocationally handicapped and unemployed, by law, is entitled to vocational rehabilitation services.

Vocationally handicapped individuals can be located and referred by any public agency, private agency, schools, institutions, interested individuals or by referring of one's self.

Definition of vocational handicap: any physical or mental disability which is of such severity that it constitutes a substantial handicap to employment and vocational rehabilitation services may reasonably be expected to render the individual fit to engage in gainful employment.

The minimum information needed to make a referral is: (1) name (2) address (3) alleged disability.

ATTITUDES

Acceptance of each individual who is vocationally handicapped regardless of socio-economic status, type of disability or ethnic origin. All are equally entitled to respect and service with human dignity.

SKILLS

Communicating the philosophy, purpose and methods of vocational rehabilitation to those of other disciplines, the public and to clients, in a manner that will produce referrals.

CASE FINDING

CONCEPTS AND KNOWLEDGE

Instructional Methods and Material

(a) Pre-training materials supplied to counselor with instructions to read and make notes for discussion or clarification. "An Introduction to the Rehabilitation Process", J. F. McGowan and T. L. Porter, Section 5 Pg. 43 - 45. DVR Procedures Manual 1-1.

(b) The instructor should discuss with and clarify for the trainee the information contained in the above references.

(c) Selected cases of different disability types as well as different referral sources should be reviewed with the trainee. These should be Status 26 cases and the review should start with a brief statement as to how and by whom they were referred.

ATTITUDES

The trainee should visit with the instructor clients of different socio-economic levels, different disabilities, and ethnic origins in their homes. This visit should be for information gathering or counseling and allow ample time for the trainee to discuss with the client "their concerns of the day". (Status 00 or 02 cases)

The instructor should structure the same type of visits with employed clients and contrast those not employed with those employed.

The opportunity to observe the disabled unemployed and disabled employed is the basis for building a positive attitude by demonstrating what can be accomplished.

CASE FINDING (Initial Contact)

OBJECTIVE: To have the trainee able to explain the Rehabilitation philosophy to workers in other disciplines and clients.

PRE-TRAINING: Mail to trainee:

INTRODUCTION: Explain to the trainee that the Rehabilitation movement is based on a definite philosophy and that the goods and services provided are in keeping with that philosophy.

ACTIVITY: Have the trainee explain the Rehabilitation philosophy as he would to a staff member of another agency. This is recorded on tape.

(1) Check the different points covered by replaying the tape. (Use a prepared check list).

DISCUSS:

(a) Items covered: emphasis, according to when mentioned, how they were stated, etc.

(b) Ask trainee to identify areas of satisfaction and dissatisfaction. Why?

(2) Play a tape relating what a social worker understood after one initial explanation of the Rehabilitation philosophy. (Note areas mentioned on check list).

(a) Play the explanation that was provided the social worker by a counselor. (Note areas mentioned on check list).

(b) Compare the two check lists to identify what was explained and what was understood.

ACTIVITY: Have the trainee explain the Rehabilitation philosophy as he would to a client, (modifications could be made with different disability groups). This is recorded on tape.

(1) Check the basic areas covered by replaying the tape. (Use a prepared check list).

DISCUSS:

(a) Areas mentioned, emphasis according to when mentioned, how they were stated, relation to client's direct needs, etc.

(b) Ask trainee to indicate the areas in which he was satisfied and those not satisfied.

CASE FINDING (Initial Contact)

(2) Play a tape on which a client told what he understood from the initial contact in which Rehabilitation philosophy was explained. (Use a check list to indicate what client related).

(a) Play the tape on which the explanation of Rehabilitation philosophy was provided for the client. (Use check list to indicate what the counselor related).

(b) List points covered by the counselor and those mentioned by the client. Note the differences.

(c) Discuss the effect of the different.

EVALUATION METHODS

The instructor arranges for the trainee to visit representative referral sources and observes his efforts, noting the skill, knowledge and attitude he uses in attempting to secure new referrals. After each visitation, his strengths and weaknesses are discussed. Positive suggestions are made related to the weaknesses. Progress is noted by the instructor.

*Special thanks to A. P. Caudill, Supervisor, Staff Development, Department of Vocational Rehabilitation, Richmond, Virginia, for sharing with the Ad Hoc Committee his ideas and suggestions regarding this possible Training Model.

10. EVALUATION PROCEDURES
REGIONAL COUNSELOR TRAINING CENTER
WEST VIRGINIA DIVISION OF VOCATIONAL REHABILITATION
P and G Building
2019 Washington Street, East
Charleston, West Virginia 25305

1. Name or type of training _____

2. Date(s) of training _____

3. Location(s) of Training _____

4. Name _____

Address _____
Street City

_____
State Zip Code

5. Are you presently employed? _____ Yes _____ No

6. Number of months employed by your Rehabilitation Agency _____

7. Caseload Assignments: (Check) Months of Assignment

_____ General Program (Field) _____

_____ Psychiatric Facility _____

_____ Social Security Recipients (Trust Fund) _____

_____ Mental Retardation Facility _____

_____ MR/Edu. Co-op Program _____

_____ Correctional _____

_____ Other, (Specify) _____

8. List job changes since completing Regional Counselor Training Program

_____ Resigned, to another Agency (Specify) _____

_____ Military Service

_____ To attend School (Specify) _____

_____ Other, (Specify) _____

_____ Promoted, (Specify) _____

9. Professional Memberships Held (Please Check):

_____None _____APA _____ARCA

_____NRCA _____NRA _____APGA

_____NASW _____Other (Specify)

10. Professional Meetings Attended in Previous Year (Check):

_____None _____APA _____ARCA

_____NRCA _____NRA _____APGA

_____NASW _____Other (Specify)

11. Type of Professional Journal Read (Number)

_____None _____Basic Theoretical

_____General Rehabilitation _____Specialized Conditions

_____Other (Specify)

12. Publication of Articles (Check)

_____None _____One _____Two or More

_____Other (Specify)

13. Job Satisfaction (Check)

_____Very Satisfied _____Satisfied

_____Somewhat Dissatisfied _____Dissatisfied

14. Maximum Monthly Earnings (Check):

$300 to $399_____
$400 to $499_____
$500 to $599_____
$600 to $699_____
$700 to $799_____
$800 to $899_____
$900 to $999_____
$1,000 or More_____

15. Long-Term Goals (Post-Training Plans)

Rehabilitation Counselor or Counseling Psychologist_____

Rehabilitation Agency Administration _____

College Teaching_____

Research_____

Specialization (Rehabilitation Counseling)_____

Social Worker_____

Work Evaluation_____

Other Work (Out of Field)_____(Specify)

_____

Unknown or Undecided_____

16. What is your general impression of the training institute?

_____

_____

_____

_____

_____

_____

17. Which part(s) of the program do you think were most valuable? Please refer to your agenda and be as specific as possible.

_____

_____

_____

_____

_____

_____

18. Which part(s) of the program do you think were least valuable? Were they least valuable because of: a) content; or b) manner of presentation? How could they be improved?

_____

_____

_____

_____

_____

_____

19. What additions to the program would you suggest? Please be specific.

20. Would you recommend this training to others? If so, why? If not, why?

21. Additional comments:

RETURN COMPLETED FORM TO:
William R. Phelps, Program Director
Regional Counselor Training Program
West Virginia Division of Vocational Rehabilitation
P and G Building
2019 Washington Street, East
Charleston, West Virginia 25305

REGIONAL COUNSELOR TRAINING CENTER
P & G Building
2019 Washington Street, East
Charleston, West Virginia 25305

11. VOCATIONAL REHABILITATION SYSTEM

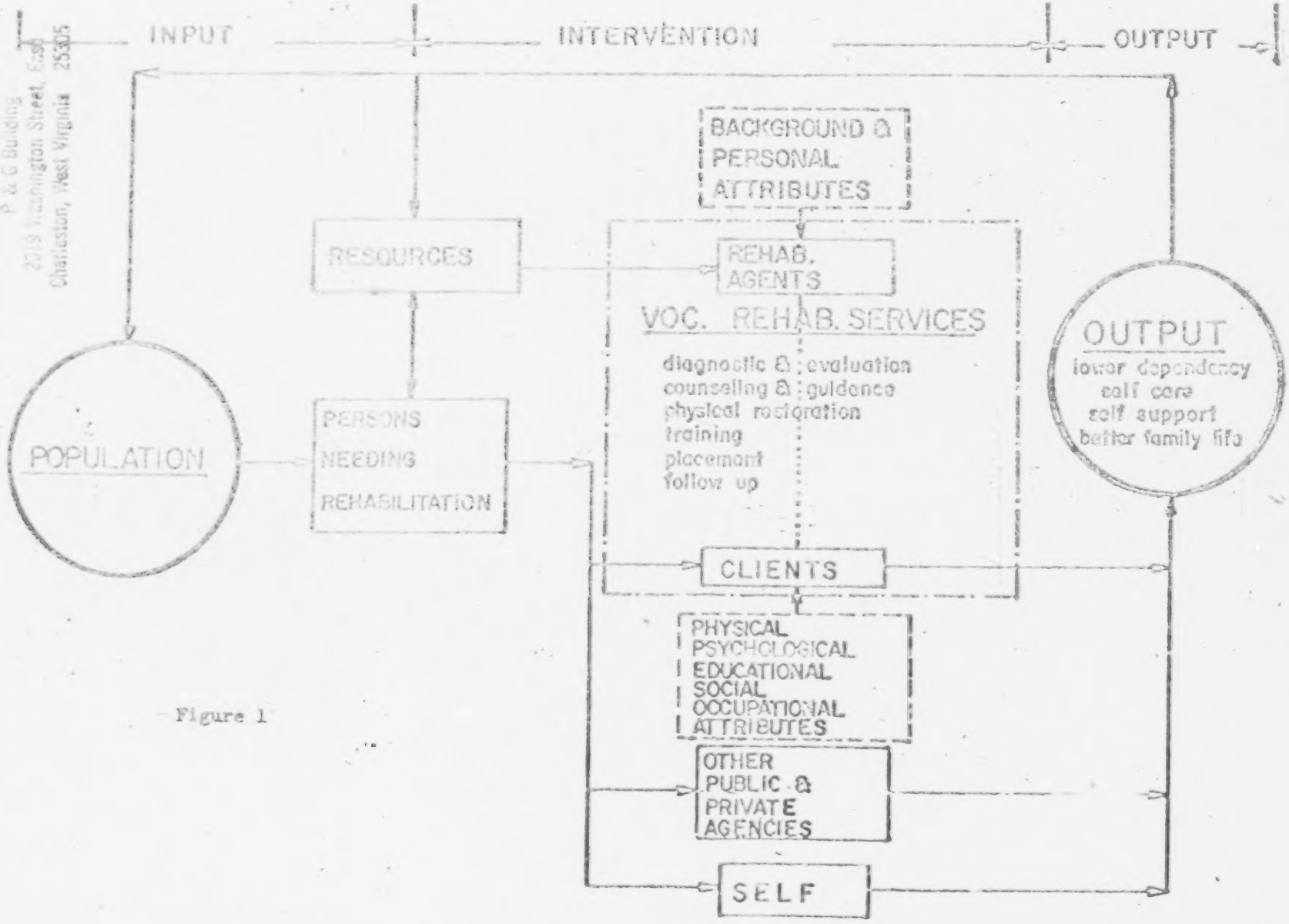

Figure 1

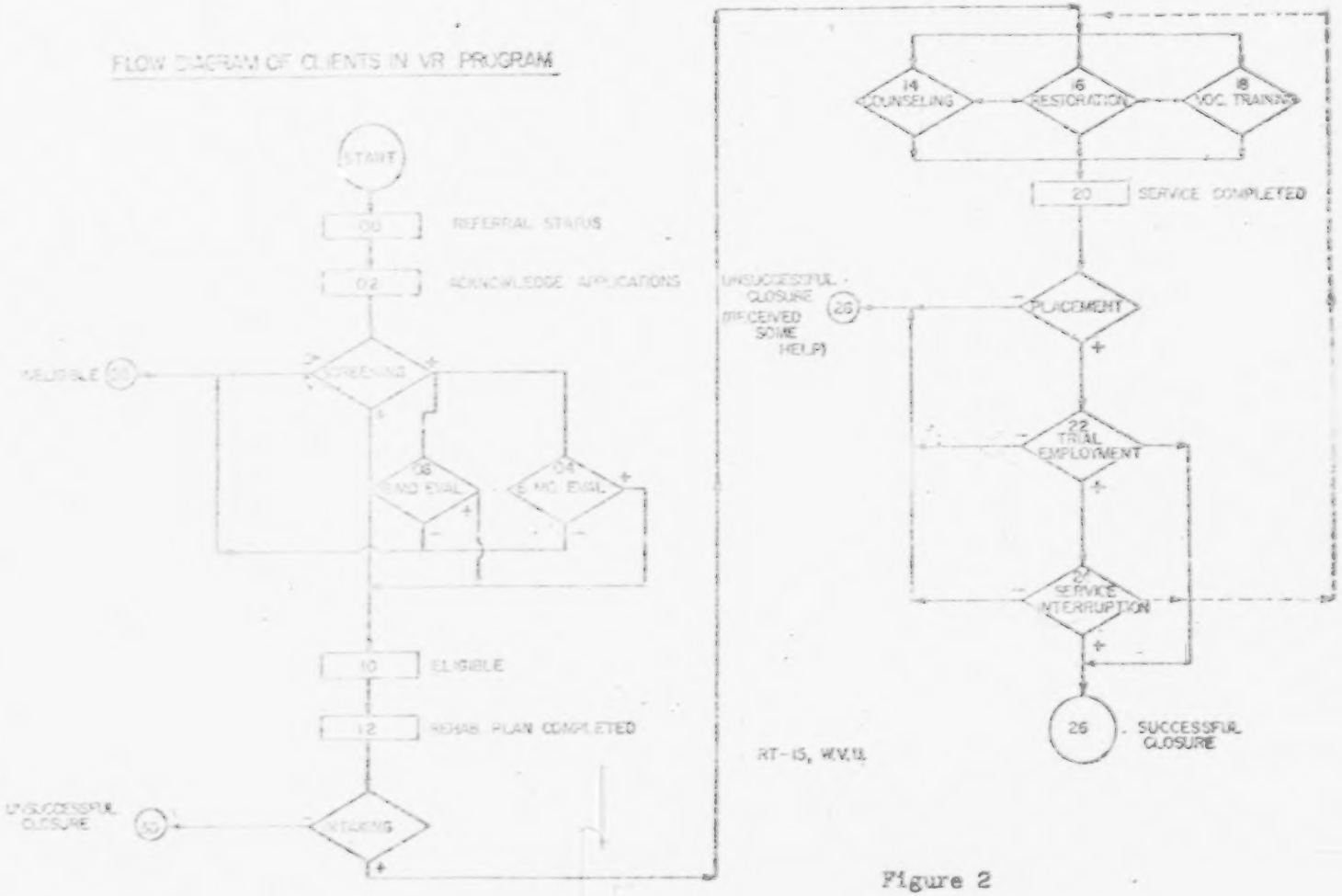

Figure 2

*Special thanks to Dr. M. S. Tseng, West Virginia University, for Figures 1 and 2

XI. COLLATERAL RESOURCES

Pathway--December, 1970
Vol.1, No.8--p.11

Appalachian Culture

By Dr. Norman Simpkins

The basic culture of Appalachia is Celtic and distinct from the life-style of the Anglo-Saxon or what I call "people of the plains." The people who came to America from Ulster were Scotch-Irish (who were really the Scotch). They did not stay near the coast, still subject to colonial British rule, but pushed the frontier farther westward to escape continuing tyranny. Besides, the chiggers and ticks were eating them up; they wanted cooler climate in the summertime and some hills and mountains to look at.

The mountaineer is not a person to be pushed where he does not wish to go nor is he submissively responsive to a shaping process. The mountaineer, like his ancestors, has always chosen to live in isolated areas reflecting and reinforcing the characteristics of an independent, free, self-reliant people to whom family solidarity and traditionalism were a way of life. Resignation to factors beyond his control has, in the past, stimulated the mountaineer to turn to God for resolution of his circumstances.

Two seemingly contradictory traits are the suspiciousness of and yet friendliness toward strangers. A person who comes into the neighborhood with authority is resented; if, however, he is on a level with and does not "talk down" to the people, he meets with warm hospitality.

Quick fighting, love of race, distrust of government, servility to no man, a taste for politics, pessimism, action-seekers who do not like routine, animal raisers and hunters—these are the characteristics of the mountain people. They are contemplative, real people who have kept many of the basic human qualities that make for a rich person-oriented culture. This person-orientedness may well be the aim of civilization once the age of cybernation frees man to find "the wisdom of a balance between making a living and making a life.

Pathway

T H E T E A M

A team is comprised of a number of distinct individuals playing a variety of different roles in concert.

The status of each team member who makes a significant contribution to further the team work is equal to that of every other staff member. Individual effectiveness is measured by the richness of usable input provided by each member, and by competence in converting constructive ideas into actual practice.

The team endeavors to achieve specific goals and effects which may be either simple or complex in nature.

The proper measures of success of the team effort are normally in the nature of improvements and alleviations of difficulties rather than absolute and total resolutions of problems.

Team morale and esprit de corps are viewed as valuable by-products of the group's efforts rather than primary goals. A well-functioning team possesses the security required to tolerate unusual ideas and a certain amount of unusual work behavior which is not under the controlling mechanisms of the team. However, the team will normally act to reduce or to alter behavior of individual members that stand in sharp contrast to the established team goals.

Normally, each team member provides that specific input and effort which his training, background, and special interests have enabled him to add to the total situation. A team member's contribution may be specialized, in which case the efforts of no other team member will overlap his own, or it may be of a more general nature, in which case he will share parts of his role with other members.

Each team member is primarily responsible and accountable for the quality of his input and his workmanship and is also, but only secondarily, accountable for the functioning of the other team members' efforts. Every member is equally responsible for integrating his work with that of the others.

The team may formally, or informally, designate one person to be its leader, or it may decide to distribute the leadership function. Leadership may be stable over time, or it may shift flexibly at various times.

A team that is engaged in difficult and challenging work in which members do not communicate extensively with each other, both formally and informally, is hardly entitled to the "team" designation.

Proper team functioning requires the members to be present and accessible with predictable regularity. A further requirement for team effectiveness is stability of membership. A team in which members are replaced frequently will be significantly hindered in the effective pursuit of its goals.

Teams evolve gradually toward maximal effectiveness over a period of time, and the feeling of social usefulness and emotional well-being of each team is, in part, determined by the team's collective productivity and work success.

Guide to Manpower Training. Colbert and Hobre, Behavioral Publications, (1971).

New Address
REGIONAL COUNSELOR TRAINING CENTER
3510 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304

EVALUATION OF JOINT TRAINING WORKSHOP OF DPH AND DVR FOR WELFARE CLIENT REHABILITATION IN VIRGINIA

Category of the participants:

Social Worker	33%
Rehabilitation Counselor	20%
Supervisor (PA)	16%
Supervisor (VR)	19%
Other	3%

Sex:

Male	69%
Female	31%

Age in years:

20-29	49%
30-39	25%
40-49	20%
50-59	4%
60-69	2%

Education:

Bachelors	65%
Masters	25%
Masters +	10%

Client population served by the professional:

Rural	6%
Urban	72%
Both	22%

Rate topics to the degree to which you have been previously exposed to them:

Basics of work evaluation:

Extensive exposure	30%
Moderate exposure	52%
No exposure	18%

Theories and practices of group work:

Extensive exposure	14%
Moderate exposure	57%
No exposure	29%

Check topic which you feel your agency is stressing as quite important:

Basics of work evaluation	61%
Theories and practice of group work	31%
Behavior modification	54%
Internal and external locus of control and attitudes of professionals working with poor	31%

Check topic in which you desire more training:

Basics of work evaluation	33%
Theories.....group work	54%
Behavior modification	56%
Internal.....with the poor	47%

Grade the quality of each presentation:

Basics of work evaluation:

Superior	2%
Excellent	35%
Average	39%
Fair	18%
Poor	6%

Theories.....group work:

Superior	6%
Excellent	40%
Average	36%
Fair	7%
Poor	11%

Behavior modification:

Superior	40%
Excellent	40%
Average	15%
Fair	6%
Poor	0%

Internal.....with the poor:

Superior	14%
Excellent	38%
Average	42%
Fair	4%
Poor	2%

Behavior modification:

Extensive exposure	27%
Moderate exposure	61%
No exposure	12%

Internal and external locus of control and attitudes of professionals working with poor:

Extensive exposure	13%
Moderate exposure	52%
No exposure	35%

Rank 1-6 topics in order of importance to your work:
1- Most important and 6- Least important:

Basics of work evaluation

1	25%
2	20%
3	25%
4	14%
5	8%
6	4%

Theories and practices of group work:

1	
2	
3	
4	
5	18%
6	12%

Behavior modification:

1	36%
2	25%
3	17%
4	6%
5	6%
6	10%

Internal and external locus of control and attitudes of professionals working with the poor:

1	27%
2	21%
3	20%
4	20%
5	6%
6	6%

Insofar as I am able, I plan to use the following ideas in my work:

Work evaluation	24%
Group work	22%
Behavior modification	32%
I-E locus of control	22%

Do you consider the training workshop to have been worth taking time out from your job to attend?

Yes	81%
No	19%

How far down this list of stages do you think you are upon completion of this program?

Awareness	8%
Interest	31%
Evaluation	61%

(Number responded to evaluation questionnaire = 57)

REGIONAL COUNSELOR TRAINING CENTER
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2019 Washington Street, East
Charleston, West Virginia 25305

A paradigm of Vocational Rehabilitation System

M. S. Tseng

West Virginia University

Vocational Rehabilitation as An Input-Intervention-Output System

A macro view of the functioning of vocational rehabilitation system may be presented by a paradigm that takes vocational rehabilitation as an input-intervention-output system (see Figure 1). A paradigm is conceived as a model or pattern that portrays the temporal, spacial, causal, or logical relationships of events by boxes, connecting lines, and positions on vertical and horizontal dimensions. The reason for considering this paradigm is that more systematic, orderly and useful approaches to the formulation of the variables and hypotheses that enter into research on vocational rehabilitation may be accomplished.

Insert Figure 1 about here

As can be seen in Figure 1, this paradigm of vocational rehabilitation system assumes three basic stages, input, intervention, and output, to complete a looping cycle. Included in the "input" end are the components of (1) general population, (2) a sub-population consisting of people who need rehabilitation, and (3) another sub-population of those who serve as rehabilitation resources.

Tseng

The second stage, "intervention", represents a phase during which vocational rehabilitation takes place. The disabled person may complete this state (1) entirely on his own resources, (2) through the assistance of public and private agencies other than those of vocational rehabilitation, or (3) via the services of vocational rehabilitation agencies. The primary role of the vocational rehabilitation agencies is portrayed in Figure 1 by the largest box (formed by broken lines) in which diagnostic and evaluation, counseling and guidance, physical restoration, training, placement, and follow-up services are to serve as vehicles for intensive client-rehabilitation agent interactions. The client comes into this box bringing with him his physical, psychological, educational, social, and occupational strengths and weaknesses. The rehabilitation agent who is there to help the client, too, brings his background and personal attributes into the picture. Interactions between the client and the rehabilitation agent through various services allow the pooling together of the client's own resources and the environmental resources that is crucial for the purpose of enhancing the client's rehabilitation potential and facilitating his rehabilitation.

The client then moves on to the "output" stage where his dependency is lowered, self care improved, self support attained or retained, and family life strengthened (taken from the SRS program objectives, 1968). The client then goes back to general population or even becomes part of rehabilitation resources in the "input." He may need further rehabilitation and move on again to the "intervention" stage, and so forth.

Tseng

To show how the client goes through the intervention phase with the aid of state vocational rehabilitation agencies, Figure 2 is presented. The code numbers shown in this flow diagram, 00-30, are those currently in use by the agencies.

Insert Figure 2 about here

Ideally, all necessary information (medical, social, vocational, psychological, etc.) on the client should be collected well ahead of time before a rehabilitation plan is completed (code 12) so that the plan, as a tentative prediction of a successful intervention, would stand the best chance of success.

Inappropriate rehabilitation plans can be costly in terms of the agencies' manpower and financial resources and in human terms as far as the client is concerned. The experience of failure resulted from an inadequate rehabilitation plan would have a confounding effect on the client who may already have experienced a number of failures and consequent rejections. This "human cost" takes on added significance as vocational rehabilitation agencies move increasingly to serve the culturally different and socially alienated. In a real sense, the overcoming of "fear of failure" in and of itself can be considered as a significant criterion of vocational rehabilitation.

An enormous expenditure of effort in client evaluation is justified if, in fact, it does provide indispensable data with

which the most appropriate rehabilitation plan can be developed for the client.

Typically, the client's medical, social, educational, and vocational data are obtained from the survey interview at the time the counselor receives a referral. This is usually followed by basic psychological testing.

Upon the identification of the need for vocational evaluation, the counselor may refer the client to the vocational evaluator for work assessment. Currently, there are four identifiable techniques of work assessment. The first of these is the occupational aptitude testing which relies on the considerable battery of tests of occupational aptitude developed for almost every conceivable kind of employment during the past generation. The second technique capitalizes on the large body of information developed through job analysis. The third approach comprises an effort to develop sets of structured work samples designed to provide the evaluator with some idea of the client's potential for training in one or another occupation. And finally, the fourth technique which is known as the situational assessment simulates actual working conditions under which systematic observations of the client's performance are conducted (Neff, 1970).

How should these different types of client's data be used? For the purpose of establishing a rehabilitation plan for him? For the purpose of predicting immediate, intermediate, and ultimate goals of his rehabilitation? What kinds of input and output data should be provided by client evaluation? How should the client

Tseng

evaluation data be used to guide an effective intervention? What kinds of client evaluation data would be needed for the assessment of the effectiveness of intervention? in what form? These and other questions can be asked with reference to the proposed vocational rehabilitation system: an input-intervention-output paradigm.

Training satisfaction as an Immediate Criterion of Vocational Rehabilitation

The author investigated satisfaction expressed by rehabilitation clients who received vocational training at a state vocational rehabilitation center. Training satisfaction was found to be negatively correlated with the client's age ($p<.01$) and positively associated with his knowledge of the trade involved ($p<.05$). It was also found that the internal-external locus of control variable was a significant predictor of training satisfaction. Internals, those who believe that they themselves have personal control over their destiny, showed significantly more satisfaction with vocational training (Tseng, 1970). However, no correlation was found between training satisfaction and need for achievement (Tseng, 1972).

Training Completion as an Intermediate Criterion of Vocational Rehabilitation

The author examined the client's psychometric measures and work behaviors as predictors of vocational training outcome (Tseng, 1972). Successful completion of vocational training was found to be significantly ($p<.05$) and positively correlated with the client's interest in occupations involving the use of verbal symbols, the

sales or distribution or the detail of office and clerical work, the working with numbers, the interpretation and communication of emotion or inner feelings, and longer periods of preparation and training; his verbal aptitude; and his motivational level, manners in the ship, attitude toward training, reliability, initiative, self-reliance, punctuality, work tolerance, ability to work with others, cooperativeness, and appearance.

Of greater importance was the findings that in predicting who was going to successfully complete vocational training, instructor's ratings on the client's work behaviors and psychological test scores on vocational interests were considerably more useful than psychological scores on scholastic aptitude, brain damage, and achievement in reading, spelling, and arithmetic.

Employability as an Intermediate Criterion of Vocational Rehabilitation

Employability as an intermediate criterion of vocational rehabilitation was related to a selected number of personality factors and work-related attributes (Tseng, 1972). Higher employability was found to be positively correlated with the client's tendency to quickly grasp ideas (16 PF Factor B, $p<.05$); his personal quality including the ability to work with others, punctuality, cooperativeness, self-reliance, appearance, courtesy, motivation, reliability, work tolerance, initiative, and attitude ($p<.01$); and with his proficiency at work including work knowledge, work skill, quality of work, care and operation of equipment, observance of safety practice, and compliance with shop rules ($p<.001$).

Tseng

When discrepancies among self-evaluation, perceived reality, and objective reality were related to employability, both self-objective reality (client's self rating – instructor's rating) discrepancy and perceived reality-objective reality (client's estimate of the instructor's rating - instructor's rating) discrepancy were found to be significantly and negatively correlated with employability.

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Sponsored Jointly by West Virginia University and the West Virginia Division of Vocational Rehabilitation

RC TP REGIONAL COUNSELOR TRAINING PROGRAM

Office of the
PROGRAM DIRECTOR

New Address
REGIONAL COUNSELOR TRAINING CENTER
3510 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304

MINUTES
Ad Hoc Committee for Joint Training
DPW-DVR Personnel (Region III)
Charleston, West Virginia
Tuesday, December 14, 1971

The first Committee meeting convened on 12/14/71 at 9:00 a.m. and adjourned at 4:30 p.m. with the following persons present:

1. Mr. Warren Harry, W. Va. Dept. of Welfare
2. Mr. H. T. Lyttleton, W. Va. Voc. Rehab.
3. Mr. John Wade, Virginia Voc. Rehab.
4. Mr. Heyward McElveen, Virginia Dept. of Welfare
5. Mr. Joseph Guschke, Maryland Voc. Rehab.
6. Mrs. Anne Reed, Maryland Dept. of Welfare
7. Mr. Jacob Armstrong, Regional Office, Philadelphia
8. Mr. William R. Phelps, RCTC, Charleston, W. Va.

The following individuals were unable to attend the original Ad Hoc Committee meeting:

1. Mr. Mark Smith, Delaware Voc. Rehab.
2. Mr. Joseph Weir, Pennsylvania Voc. Rehab.
3. Paul Leary, Ed. D., R & T Center, Institute, W. Va.
4. John Yankey, Ph.D., W. Va. Dept. of Welfare
5. Mrs. Margaret Burk, Pennsylvania Dept. of Welfare
6. Mrs. Payne, Delaware Dept. of Welfare
7. Mr. R. F. Lee Wolf, Regional Office, Philadelphia
8. William Jenkins, Ed. D., Pennsylvania Voc. Rehab.

In the absence of Mr. Henderson or Mr. Wolf of the Regional Office of RSA, Mr. Phelps gave a brief overview, introduction and background regarding the need for joint training. Mr. Jacob Armstrong from the Community Services Administration of the Regional Office pointed out the need for such training

and the support to be expected from his organization. Each DVR person and DPW person present from Virginia, Maryland, and West Virginia gave a brief history regarding past training efforts and identified some of their needs for future training.

The Program Director (RCTC) gave the following purpose or mission for joint training and the charge to the Ad Hoc Committee:

1. An effort should be made to develop an overall curriculum for Regional joint DVR-DPW training if there were enough commonality of needs, problems, etc. among states within Region III.
2. If possible, depending upon variability and uniqueness of needs by states within Region III, attempt to develop specific models which would be a part of the core curriculum but could meet individual state needs as required.

After considerable discussion there appeared to be the following three needs identified by consensus of the group:

1. Problems dealing with administrative areas.
2. The mechanics of getting the job done.
3. Problems relating to program areas.

Mr. Armstrong summarized the following needs which again appeared to be a general consensus of Committee members present:

1. A need to train high-level administrative staff should be one factor considered in curriculum development.
2. Training needs in the area of communication.
3. Worker role identification; role, function, and responsibility of various team members.
4. An umbrella or core curriculum with special adaptations or models depending upon various state needs.
5. Some part of the curriculum content should deal with the need for making joint decisions.

6. There was felt to be a need for DVR-PA confrontations as a part of the training effort; e.g., group involvement.

7. Some attention should be given to reporting systems.

Two approaches were identified as follows for the delivery of training: (1) to prepare the curriculum for delivery services personnel, and (2) to prepare curriculum for administrative staff including top management, middle management, and first-line supervisors. (The Committee realized that this could be affected by the size and structure of the agency.)

Little attention was given to methodology or modes of presentation of material other than the idea of much group involvement, group dynamics, and an "unfreezing process first." In other words, rather than spending time on history, legislation, philosophy, etc. the group felt that it would be well to cover these factors but to interweave these areas into worker role identification or, "how do I fit in and what contribution can I make as a team member."

The next area for discussion was the groups' response to a rough draft of a tentative proposal prepared by the Program Director, RCTC. Mr. Phelps pointed out that much of the content of this rough draft was derived from prior contacts with agency staff (DPW and DVR) of Maryland, Virginia, West Virginia, Kentucky, North Carolina, Regional Office personnel and material received from the ICD conference held in New York in August of 1971. This rough draft proposal was gone over rather thoroughly for a one-day session and many helpful suggestions, comments, and positive criticisms were given. It was pointed out by the Program Director that the proposed curriculum was very weak as it related to the Welfare agencies and the Social Case Service processes.

Mr. Harry, Mrs. Reed, and Mr. McElveen indicated they would help to strengthen the areas of the proposed curriculum relating to the Welfare agencies.

SUMMARY:

1. It was agreed that the Welfare Agencies' personnel would help to strengthen this particular phase of the curriculum, particularly as it relates to: (a) defintion of terms; (b) the social service process, (c) worker role identification; (d) eligibility for DPW services; and (e) organization and administration of DPW.

2. The Program Director agreed to revise the rough draft of the curriculum with all suggestions, comments, and recommendations presented and forward a revised draft to Committee members within three to four weeks for further reactions.

3. After the Committee members have time to review the second rough draft copy, a second Committee meeting will be held either in the Regional Office in Philadelphia or some north central location in West Virginia as possible sites. It was suggested that Martinsburg, West Virginia be considered. Hopefully, the Committee can meet again the latter part of January or early February, 1972.

4. The Committee seemed to feel that the Regional Counselor Training Program could help with joint training efforts on a Regional basis prior to the full development of a comprehensive curriculum. (One such training program scheduled for Hagerstown, Maryland, January 25-26, 1972.)

5. Mr. McElveen reported that he and Mr. Wade had been presenting a two to three-hour session as part of the counselor induction training at Virginia Commonwealth University, Fishersville, Virginia, as it relates to joint training efforts. Mr. McElveen suggested and recommended that other DVR-DPW personnel within the Region be invited to participate and possibly rotate presentations within Dr. Cull's training program. He felt that this would do much to strengthen their efforts in this respect. The group agreed with this suggestion, and Mr. Armstrong indicated that he would present this proposal to the Regional Office for consideration.

The Ad Hoc Committee felt this to be a rather significant undertaking and that proper time should be given to the development of the best curriculum possible, fully realizing there should be considerable flexibility. The Committee seemed to feel that it might require one and one-half (1½) to two (2) days to complete the task of finalizing this curriculum.

The Program Director (RCTC) reported that the second draft of the proposed curriculum would be shared with appropriate personnel from those states not present (Pennsylvania, Delaware, Washington, D.C.) at the first Ad Hoc Committee meeting for their suggestions, comments, and recommendations.

The meeting adjourned at 4:30 p.m., December 14, 1971.

William R. Phelps, Recorder
December 23, 1971

SERVING THE ILL AND HANDICAPPED

It is axiomatic that the doctor treats not only the patient but also the patient's family. Casework services to the chronically ill or physically disabled in an even larger sense must be services to the entire family, with the focus on the problems presented by the patient and the effect on the family of his disability. Family attitudes and reactions to his situation are of paramount importance to the patient's adjustment to his illness or handicap, and his adjustment is a significant factor in the social development of the family.

Since the Aid to Permanently and Totally Disabled program is the youngest in the family of categories in public assistance, many of the cases coming to the agency in the beginning are cases of long duration, and the family attitudes built around them are well established. It may be, however, that the certification for an assistance grant may furnish a turning point from which progress to healthy emotional relationships may be effected. Dependence on some one else resulting from the incapacity may be immeasurably decreased by the financial emancipation which the assistance grant will bring, but there is also the dangerous possibility that whatever resistance to dependency may have existed will be finally crushed by the complicated process of determining eligibility on the disability factor.

The necessity of protecting the program from malingerers and neurotics has created procedures which may contribute to defeat its own rehabilitative objectives. A physical examination is made by a physician of the client's choice, but this may be followed by one or by several examinations by specialists selected by the medical review team, and the caseworker makes a careful study of the social factors related to the illness. Often there is a long period of waiting for a decision, and all the time the process builds up the desirability of painting the worst possible picture of the illness. In fact, if the client is to attain success in his efforts to obtain financial assistance he must substantiate total failure as a person. As one client explained it, "I had no idea how much there really was the matter with me until I got into this. I guess I've been neglecting myself and expecting myself to function normally, when actually I am a very sick man." It is little wonder that the caseworker sometimes presents the final determination of the medical review team with the regretful statement that she has bad news for her client: it has been established that he is not totally and permanently disabled.

Unless great damage is to result from this process which emphasizes negatives, the caseworker must have been building defenses against the emotional impact of the decision. The client has applied for assistance because he believed himself to be disabled. If he is successful and is awarded a money payment on this basis, this success may crush him. If it is determined that he is not disabled, his reaction is likely to be the familiar resentment of the ill, who continually suffer from lack of sympathy and the conviction that no one realizes how serious their afflictions really are. To tell the client bluntly that he is not ill and is able to go to work and support his family is not likely to convince him, and casework services frequently are needed more by the applicant who is denied assistance than by the one who is approved.

Both are limited by their estimate of their own capacity and both need help in analyzing their job potentials and ambitions. "Never give a man up until he fails at a job he really likes-something he wants to do," cautioned a wise rehabilitation counselor. When one considers how many people go through life never knowing any joy in their jobs, never doing something they want to do, it does not seem strange that some reach that stage of distaste for their day-to-day routine at which they take refuge in convincing themselves they are too ill to continue their employment. To such persons occupational counseling and vocational training may be more therapeutic than anything the doctor orders, and may make of this experience a milestone in the building of a career.

The approach to each case requires careful analysis of the realities of the situation and the personality of the client. There are, however, three over-all groups into which most cases will fit: (1) cases with a prospect for either partial or complete recovery, (2) cases with permanent handicap which may be partially or completely surmounted by developing remaining potentialities, (3) hopeless cases that have no chance for improvement and are without capacity for training or development. In these unfortunate cases the worker can hope to assist patient and family in accepting the situation and in focusing attention on the positive factors in even the most difficult situation. Perhaps there may be some area of self-care that can be used so that the patient will feel less dependent, or planning can be done to emphasize any remaining capability.

> "Bill loves to eat doughnuts," explained the wife of a victim of Buerger's disease. "He's lost all his fingers, but he has one thumb. The hole in the doughnut slips over his thumb so he can eat it without anyone feeding him."

To be a successful "gloom chaser" requires a very high degree of skill and utmost tact, for sensitive souls are quick to detect the artificial or insincere response to their own despair. Sometimes the only possible service is to help the family of the patient to understand his unreasoning rejection of all they offer. To achieve that understanding of others which creates self-forgetfulness, even in an atmosphere of emotional tension and physical weariness, is indeed difficult, but it can result in that serenity of soul which is man at his best.

It would seem that casework with the first group should be comparatively simple. With provision made for treatment and a degree of financial security for the duration of illness, two of the big problems are solved. But the third problem, acceptance of the treatment plan and utilization of the available services by the patient and his family, persists in varying degrees over the entire treatment period. The relief of urgent financial need removes an acute anxiety, but it also removes one of the most compelling reasons for recovery. There is also that strange paradox of the transfer of fear of illness to fear of not being ill, with sometimes a combination of both these fears. The illness of long duration has sheltered the patient from active participation in everyday life until he doubts his ability to assume responsibilities he once carried and his desire to return to normal activity is in direct conflict with his reluctance to emerge from the abnormal situation of disability where little is expected of him.

Other fears crowd in on him. He is afraid of surgery, afraid of hospitalization, afraid the doctors do not really know the degree of his illness. In cases where artificial appliances are included in the physical restoration service, he is afraid that failure to adjust will destroy the cherished hope that this is the way to normal living, and he postpones the day when he must make the test. The fear of failure and inadequacy persistently drives him back to the refuge of illness or handicap where he will have no responsibility.

Added to all these personal fears is a new anxiety. He may not be able to provide for his family as well as the assistance check does, and he does not want to know this himself, nor does he want his family to know it. His inadequacy is excused now because of illness-he is afraid to get well!

It is easy to say that he needs self-confidence and hope, but building self-confidence and cultivating hope needs unwavering patience, the ability to lend courage and inspire ambition. The caseworker who is herself easily discouraged does not have too much to offer. Here too it is of utmost importance that the family will be able to recognize these conflicts and will be able to help in dealing with them. The sooner after the onslaught of the illness or disability planning is done for the life beyond its duration, the greater the chances for success and for normal adjustment of the individual.

The second group is subject to all the fears and doubts that plague the first, and in addition there must be acceptance of the loss of a portion of the physical ability which has been normal until the onset of illness or handicap. This client is facing the difficult fact that he must be less a man than he was-he must face his former associates who know he is less capable than formerly. He dreads and hates pity from his fellows, yet he seeks and clings to it even to the point of self-pity. He hates the dependency on others that his disability has forced on him, but he clings to it to protect him from having others depend on him. Beset by fears and engrossed by emotional conflicts, the patient's recovery is retarded and his attitudes concerned with relating himself to his surroundings become increasingly distorted.

At this point few things are more shattering to his equanimity than to be told that his illness "is only in his mind." Fairly normal mental and physical health are necessary to objective acceptance that all illness is partly psychosomatic and that frequently physical healing occurs more quickly than does the accompanying mental disturbance.

The caseworker needs to bear in mind the patient's need for understanding, but he needs to be more specific in his analysis in terms of what the individual problem is that is to be understood and how he can help to bring about this understanding. This study embraces the total situation, but relates especially to the family of the patient. Does the patient get enough sympathetic attention, or is he perhaps smothered with it? Is he encouraged to do for himself what he is able, or is all initiative and responsibility taken away from him? Is family planning shared with him to the extent of his ability, or is he excluded from the developing pattern of family events? Does he receive both love and respect from his family, or is it just pity? Does he himself want to get well, and

does his family really actively want his recovery? Is the building of self-confidence of the permanently handicapped person hampered by lack of confidence on the part of the family? In short, the analysis of the patient's problem includes all the factors which either help or hinder his progress.

What to do about the situation after it is analyzed must vary with each individual and with the diversity of circumstances involved, and, while no specific formula will apply to all cases, there are some general principles that should be kept in mind. Even the best rules are subject to exceptions, but these exceptions should be made only after thoughtful consideration. No matter how heart-tugging the client situation, the worker needs to avoid personal involvement. Warm sympathy must not interfere with objective professional judgment. At no time should the caseworker forget that he is a social worker, not a medical practitioner, and no matter how competent he feels to diagnose and prescribe, he must discipline himself and support in every way possible the advice of the physician in charge of the case. Joining in a conspiracy to deceive the patient "for his own good" is usually a mistake. Sincerity is a priceless factor in client-worker relationships, and there are few things as comfortable to live with as truth tempered with kindness.

Encouraging a person to rise to the limits of his capacity does not preclude a realistic evaluation of his capabilities. It is a cruel thing to lay the foundation for frustration, disillusionment and humiliation by encouraging a person to believe that he is something he can never be. Perhaps one of the things he needs most is to revise his standard of values and to recognize that the commonplace, unglamorous task may serve the needs of fellow men and provide him with the opportunity to contribute to his community. The men who read gas meters and keep barbar shops perform essential community services, and they may glean more friendly greetings during the day than the city mayor or the banker. To be able to do a little task well should be a source of honest pride, and to earn only a fraction of one's own subsistence is a notable achievement if it represents maximum capacity of the individual.

Because public assistance workers must think in terms of money needs and money grants, there may be a danger that they sometimes forget that rehabilitation in its largest sense is only incidentally concerned with money. Rehabilitation of the spirit, or restoration of the ability to take a normal place in the complex business of living, its laughter, its tears, its understanding and sharing, may mean vastly more to the individual and to those whose lives he touches than would his mastery of an industrial or technical skill.

Perception: An Approach to Understanding Motivation

Paul E. Eiserer, Ph.D*

1. Perceptual approach to understanding motivation

Many of the issues of perceptual psychology are stated as basic tenets.

a. Each person lives in his own unique, private psychological world. He has his own thoughts, feelings, attitudes, values which are organized in his own particular way.

b. A person reacts to the world of events and people as he perceives it, not as someone else sees it.

This is an exceedingly difficult idea to incorporate into our daily lives. When we are displeased, annoyed, irritated, angry, or otherwise perturbed by another person's behavior, it is usually because he is not reacting to the world as we perceive it. We forget that he is responding to his world, not ours. This simple notion is at the root of much misunderstanding, controversy and disagreement among people.

c. When we understand how another person looks at things, we are able to make more sense out of his actions. Behavior which, to us, appears foolish, nonsensical, inappropriate, maladaptive, ornery or whatever takes on a quite different aspect when viewed from the standpoint of the person behaving. Although a person may, in retrospect, see his own behavior as undesirable, he sees his behavior as the best he can do at the moment of action. If we too could experience the events leading up to some action of a person, we would see that his behavior makes a lot of sense.

d. Believing is seeing.

We are aware of the old saying that seeing is believing. This is our way of validating our observations of things by first hand sense perception. To seek consensus from another, "do you see what I see?" is a way of testing our sanity.

It is also true that believing is seeing. That is to say, we look for what we want to see, we listen for what we want to hear. Perception is highly selective. Each person is sensitive to selected aspects of his environment, including people.

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In a very real sense, each of us creates his own environment. Although it is true that we are shaped by influences from the time we are born, it is also true, but we sometimes forget, that we play a part in constructing the kind of inner world we want to inhabit. Man is more than creature; he is also creator!

It is a common observation of our human nature that we like to take credit for creating our successful ventures but disavow responsibility for the messes we get ourselves into. We are ingenious in finding causes outside ourselves to account for behavior we don't like; e.g., genetics, parents, economic circumstances, malevolence of other people, etc.

e. To understand another person's motivations and actions we must learn how to see things as he does. <u>This does not mean that we agree with him.</u>

By being empathic and sensitive, we seek access to the private world of another person. When we get "inside his skin", so to speak, we become clearer about his ways of perceiving, which form the bases for his actions. We discover that he acts in terms of <u>his</u> feelings and knowledge of events and people, not on the basis of <u>our</u> perceptions.

While the external environment is important, it is the way a person perceives it that determines his reactions.

REHABILITATION IN PUBLIC ASSISTANCE AND THE RELATIONSHIP BETWEEN THE SOCIAL WORKER AND THE VOCATIONAL REHABILITATION OFFICER

Rehabilitation is the term applied to that combination of services and facilities designed to aid people to regain lost value and realize new horizons. The rehabilitation process must work within the potentialities of each individual at a given time. The goal for some persons will be reemployment, for others perhaps greater self-sufficiency, such as the ability to assume self-care rather than live in a nursing home.

Although it is recognized that rehabilitation in its broadest sense really encompasses all activities of a public welfare department. However, this discussion will be limited to those activities which are directed toward returning disabled welfare recipients to the highest level of self-support of which they are capable.

Usually it is the social worker sho is the initiator of the process which may eventually lead to the rehabilitation of the individual. Occasionally, of course, we may see a client coming to the agency who is self-starting, so to speak, and completely aware that he is in need of a specific service to enable him to become again self-supporting member of the community. More usually, however, it is the social worker who, as a result of her analysis of the situation, sets off the spark and gets things going. Therefore, it is essential that social workers begin with a real conviction that human beings have a much greater capacity for overcoming hardship and flustration than may be apparent, and that basically all people want to be independent, contributing members of society.

The following five points are vital for any successful rehabilitation process: (1) The necessity of starting with the conviction that people are

capable of change; (2) the need to keep the family in perspective; (3) the need to proceed slowly, without pushing; (4) while still reaching out to help; and (5) recognition of the values of a coordinated team approach.

There are many steps in the rehabilitation of individuals. First, the casework or the social rehabilitation must take place, with the focus being on the client and his feelings about his problem and what he wants to do about it. If there are any major medical problems, they must be cleared up prior to the time the vocational rehabilitation officer can do his job properly.

Basic to effective rehabilitation is the availability of certain services. It is important that adequate assistance be given individuals so that they will be relieved of financial stress and thus be able to concentrate on other important factors related to their achievement of self-sufficiency. The agency eligibility factors must be administered in such a way as to respect the dignity and worth of the individual and be applied by the social worker with an impartial, non-judgmental attitude. She must continue to maintain a continuing supportive role with the individual and his family.

Having completed the social rehabilitation the client is now ready to be referred to the second team member, the vocational rehabilitation officer.

Normally, the rehabilitation officer will start out with counseling on the problems which the person has brought to light and, if they are major problems, give assistance to him in working them out as they pertain to the vocational rehabilitation; with the primary objective of returning the individual to a constructive place within the community

and of course, to make him totally self-supporting and self-sufficient. In many cases, the total objective will not be achieved, however, a partial achievement of this objective is as good as a total rehabilitation.

After the initial counseling, a decision must be made as to what method of rehabilitation is going to be used. Many cases may only require the minimum amount of retraining or rehabilitation. In other cases, it may be determined necessary that the individual be retrained into a new line of employment, and job placement upon successful completion of training.

The value of the team approach in the complicated process of rehabilitation cannot be over-emphasized. When all resources in a community are brought into play, and each agency is clear on its function, knows what the other is doing, and all are working toward a common goal, it obviously follows that the whole process should be smoother and faster. During the entire period there must be frequent case conferences in which function is clarified and roles assessed.

The social worker and the rehabilitation officer functioning within the program may cooperatively develop plans for vocational rehabilitation and social refunctioning of each client. This team effort will require the social worker to focus directly upon the client and also to maintain prime responsibility regarding the client's family to avoid disruption as he pursues his rehabilitation plan.

The rehabilitation officer will be primarily concerned with those aspects which relate specifically to the client's vocational adjustment.

Each agency will commit their respective resources and follow through on

all aspects of their individual plans.

Social workers and vocational rehabilitation officers will exchange information concerning clients progress and other significant information which is relevant to the case. Case dictation must be kept current.

A joint review of individual cases may be made periodically by staff at which time progress will be assessed and appropriate modifications made if necessary.

CONCEPT, FUNCTIONING, METHODS AND PHILOSOPHY OF THE PROFESSION OF SOCIAL WORK

What is Social Work?

Social work is an institution of modern society which has its roots in philanthrophy ("practical benevolence for mankind"). While the traditional idea of ameliorating the social distress of the underprivileged ("relief of the poor") remains, the meaning of "social distress" and "underprivilege" has undergone a change in this century. They are seen as both psychologically and environmentally derived, as having no class distinction, and as affecting adversely not only the family but also the community of which the family is a part.

How Does It Function?

The organization through which social work functions is the social agency. Initially the social agency was set up and maintained solely by the efforts of philanthropic people in the community. These "voluntary" or "private" social agencies exist today in larger urban areas. They are supported by voluntary giving from all the citizens usually through a system of "federated fund raising." This is called by various names: Community Chest; United Appeal, etc. "Councils" of social agencies are a necessary part of these community chests, their purpose being to co-ordinate the efforts of all private agencies to meet old and new social needs. The methods of social work are employed in both fund raising and social planning.

The passage of social legislation, especially since the economic depression of the 1930's, has resulted in the creation of government agencies to administer that legislation. The intention of these laws and the way in which they are administered determines whether government agencies can be called "social agencies: in the meaning social work attaches to the term. When the intention and the method of carrying that intention out are remedial, government agencies are social agencies ("public welfare" agencies).

The developing importance of "mental health" (emotional maturity or stability) in medicine in determining causes of illness and in effecting its cure, has resulted in social work becoming an important medium of treating illness. In hospitals and clinics for the acutely and chronically ill, for the physically incapacitated, for the mentally ill and mentally defective, social work is one of the "disciplines" (professionally derived methods) employed in treatment. The total treatment planned by the doctor is therefore "multi-disciplines" (a team effort).

The development in the administration of justice of the concept of the rehabilitation of the "offender" has resulted in social work being introduced as a service to courts and penal institutions. In the courts, probation officers assist the magistrate or judge by providing "pre-sentence reports" (social histories) on the offender. Acting on the basis of these reports and the nature of the offence, the judge may place the offender "on probation" (social work treatment in the community). In prisons, social work is variously used in rehabilitation. Post-prison or "after-care" services are often provided by private agencies.

The development of the idea that acceptable social deportment is learned by pleasurable associations in natural groups within the community, and within institutions, has resulted in social work being employed to develop and direct such groups. Employing recreational devices, social group work is intended to treat deviant conduct, stimulate the desire and provide the opportunities for a fuller life.

The development of social security legislation and of community planning organizations whether governmental or private, has brought social work into the field of social research. The growth of large governmental agencies and of private agencies has resulted in social work being employed in their administration.

The continuous development of all the above functions of social work is its ethical responsibility. Through appropriate "social action" social work seeks to better existing institutions of society and to create new institutions to meet newly emerging needs.

What Are Its Methods?

Its methods are (1) social casework, (2) social group work, (3) community organization, (4) social research, (5) administration. These are commonly based upon a knowledge of the social sciences: psychology, sociology, economics, social anthropology, political science, social research, etc. Each includes skills and techniques unique to it but not unrelated to the others. All require the exercise of the individual talent of the practitioner; on his knowledge, professional judgement and devotion depend the success of the method he employs. They have evolved in the past 50 years from a combination of academic scholarship and agency practice. The close relationship between the universities' professors of social work, the profession, and the social agencies ensures their constant refinement.

These methods are learned in the schools of social work; it is here that the body of knowledge, the methods, skills and techniques of social work have been co-ordinated and enunciated.

What Is Its Philosophy?

The beliefs on which social work is founded are essentially those of democracy. It is assumed that the social work practitioner (the social worker) holds these beliefs as his own; that is, he: (a) respects the dignity and intrinsic worth of all people regardless of their differences, (b) stands for an orderly society and respects and upholds its just institutions and laws; (c) accepts the right of all people, within the bounds of law and society's safety, to self-determination in directing their lives; (d) possesses a highly developed balanced social conscience which prompts principled action to ensure social justice for all citizens and the remedy of social suffering wherever it is found.

The ethical implications of holding these beliefs demand that the social worker: (a) prepare himself for his profession through appropriate study

at a school of social work; (b) use every opportunity thereafter to deepen his understanding; (c) identify himself with his profession in the effort to refine and improve professional practices; (d) assume willingly his obligation to give the service he is employed by his agency to give, and to employ his professional knowledge to the betterment of the agency's standards of service.

BASIC CONCEPTS, METHODS, SKILLS AND TECHNIQUES OF SOCIAL CASEWORK

Basic Concepts

The caseworker works with the individual and his family in such a way as to enable him and his family to achieve socially desirable satisfactions in life. Basic to this enabling method are certain psychologically derived beliefs. (a) Each individual helped by the caseworker (client) differs from every other individual. The social problem he suffers may be similar to that of others, but its causes differ, its development has differed, his capacity to deal with it will differ. (b) Each client has feelings about his problem which must be allayed or understood before he can begin to overcome his problem. (c) Each client will have built up ways (defences) of relieving the discomforts of his feelings, which are revealed by his words and behaviour. (d) Each client's problem derives from both subjective (personality) and objective (environmental) factors in varying degrees of intensity and complexity. (e) The behaviour of all people is motivated by feelings (the emotions) as much as if not more than by intellect.

These concepts comprise the "approach" of the caseworker to the client. This approach ensures that the client will be met sensitively, that his feelings will be respected and not violated, that he will sense at once the caseworker's concern for him, desire to understand him and to be of help to him.

Method and Skill

The caseworker's method of helping is based on scientific knowledge and procedures and is made effective by the relationship he has with his client.

The acquisition of scientific knowledge is a lifelong quest which is best begun in undergraduate years and continued in a school of social work.

The scientific procedures followed by the caseworker are: (a) the gathering of accurate social data (facts and clear objective observations) about the client's problem and about his capacities; (b) the study of this social data from criteria (established accepted generalizations) appropriate to the case (this is deductive reasoning); (c) drawing tentative conclusions as a result of this reasoning, or formulating a "social diagnosis," or assessing the problem and the client's capacities; (d) the development of a tentative plan of treatment, in which the client shares, which is within the functions of the social agency to carry out; (e) determining a goal of treatment which when reached will terminate the help given.

The supreme skill in casework is that of the ability of the caseworker to form a relationship with the client. The nature of this relationship consists of the "anchorage, acceptance and understanding" (see Appendix IV) which the client finds in the caseworker, which gives him a sense of worth and the determination to do something about his problem and about himself.

Techniques of Social Casework

(a) "Levels" of casework practice. The function of the agency will determine to a large extent the level or intensity of the casework performed. The education, training and experience of the caseworker is another determining factor. These terms were devised by an authority on casework practice (Florence Hollis) to define levels: environmental modification; psychological support; clarification; and insight development. The casework performed in this agency encompasses the first two; the first cannot be performed without the second, but the second may be the sole need of a few clients. The third and fourth levels (or techniques) are usually employed in controlled settings (such as institutions, hospitals, clinics) where psychiatric consultation is available and the client can be reached regularly.

(b) The interview is the heart of the casework process. It is in the interview that the casework relationship is formed. It is by means of the interview that the environmental help is planned and psychological support necessary to its fulfilment is given.

Beginning in the first interview, the caseworker effects a speaking relationship with the client, a rapport which gives the client confidence in him. In doing this, the caseworker's manner will be warm, natural, outgoing and at ease. In this interview, the client states what his problem is, as he sees it. Professional skill is involved here, first in winning the client's confidence for the caseworker and second in focusing upon the problem the client states is his. The caseworker restates the broad aspects of the problem and interprets how the agency can help him to solve it. Certain practical things may have to be done, some by the client, some by the caseworker. The time of the next interview is set and its purpose explained. The keynote of this interview is to give the client some encouragement that he can re-attain his normal situation in life or a satisfying alternative.

In this interview and subsequent interviews this necessary information is obtained: the usually accurate identifying data; the client's major attitudes, aims, ambitions, way of thinking and feeling about people and situations; his general health and that of his family; his progress in school or on the job; his relationships in his family; the major events and relevant persons in his life; his home and social setting; the roots of his problem as well as its manifestations and ramifications.

(c) Collateral interviewing. It is frequently necessary to obtain information from and to enlist the co-operative assistance of other agencies, professions, organizations and people in the community. The cardinal principles in collateral interviewing are: it is done with the client's knowledge and consent; it is done in his interests; it carries a professional guarantee that his confidence will not be disclosed beyond the point of necessity.

(d) Recording. Recording the interview-and the activities such as collateral interview, case conferences, letters-is an integral part of the casework process. It is also an integral part of agency administration.

The case record follows the scientific process implicit in the casework

method. From the facts and observations recorded, conclusions are drawn and recorded; the steps to be taken, that is, the planning, should be put down. Conclusions and planning may change as the casework progresses, and these too are recorded.

Frequently the data is a composite of information obtained on application forms supported by data required to establish eligibility for services or benefits. The caseworker's observations form a part of this study.

Case records are dictated in simple narrative or story form whether formal headings (such as those required in eligibility studies) are used or not. These are the kinds of recordings:

(1) Chronological recording. Following the record of the in-take interview, entries are made under the date of each interview of activity.

(2) Summary recording. Following the diagnostic statement, one entry may summarize activity over a period of time. Care must be exercised to record administrative factors meticulously.

(3) Process recording. The interview is recorded in order to reflect the dynamics of the interview. This is not a "total recall," but a careful recording of the caseworker's direction of the interview, his observations, questioning and interpretation. Not all casework is recorded in this way, but it must be done in cases involving child welfare. Part of these records may have to be used as evidence for court purposes.

(4) Form records. Forms may provide a means of recording in the future. Diagnostic thinking and casework planning should always be included in the appropriate places on the forms. Narrative chronological entries on separate pages are necessary when problems and activities require it.

SOCIAL WORK WITH THE DISABLED WELFARE RECIPIENT

I. OBJECTIVES OF THE REHABILITATION PROCESS:

In the public welfare programs, rehabilitation is a broad concept, which is concerned with personal and social handicaps, as well as physical or mental disabilities. The objectives of rehabilitation services are, (1) to enable the individual to realize his optimum capacities for more stable personal, social, and family functioning, including self-support and self-care; (2) to arrest further loss in functioning; and (3) to increase or develop such capacities.

Obtaining these objectives are particularly important in American society which places great emphasis upon self-sufficiency, hard work, industriousness, contribution to society, and upward social mobility of the individual. To the extent that the handicapped person is unable to obtain these goals, he suffers a loss of personal dignity, prestige, and self-esteem, both as a member of society and as a member of a family.

II. SOCIAL WORK IN THE REHABILITATION PROCESS:

Social work, an enabling process, is a vital part of all rehabilitation efforts, particularly in welfare settings. It seeks to treat and effect change in various kinds of social, emotional, and physical problems that affect the social functioning of individuals.

Social work is based on beliefs: (1) in the worth and dignity of the individual; (2) that each human being has potential for progressive growth and change; and (3) that each human being is different regardless of generalities and similarities among men. (4) The right of self-determination.

III. THE ROLE OF THE SOCIAL WORKER IN THE REHABILITATION PROCESS:

The social worker is concerned with bringing about improvement in total social functioning of the individual within the limitations imposed by internal and external realities. In common with other helping professionals, the social worker is client oriented. In contrast to some others, however, the social worker is also family and community oriented. The social worker uses the tools of psychosocial understanding, assessment with the client, and development of an appropriate service plan for modifying or resolving the problems of the individual. This enables the social worker to provide the team with a comprehensive and continuing overview of the client as a total functioning human being.

The social worker is expected to have knowledge of himself as a helping person in order to understand the client, the client's family, and the community in which the client lives.

A. Understand the Client

With understanding and acceptance of limitations of self, as well as those of his clients, the social worker works to help the client achieve self-fulfillment within his capacities. Through the casework method, the social worker's goal is to enhance the worth and dignity of each individual. The client is enabled toward a better understanding and acceptance of himself, taking into account his limitations. Everything the social worker says or does should demonstrate to the client the worker's belief in the client's self worth. The social worker must have a realistic feeling toward and a sincere acceptance of who the individual is, what are his strengths and weaknesses, and what he can do.

B. Understanding the Client's Family

In order to individualize the client, to assess his needs, and to utilize the resources to meet them, the individual must be known not only as himself, but also in relation to his surroundings. The family unit is usually the center of the client's surroundings. The social worker must understand family functioning and relationships in order to understand and help the individual. The social worker seeks to understand the family's view of the client.

C. Understanding the Community

The social worker in public welfare needs to have knowledge and understanding of community resources in order to utilize them effectively. Public assistance is not the full answer in helping the client, but the social worker reaches outside the public welfare agency to develop other resources in order to help the client reach his full and most acceptable level of existance. The social worker should know what services the community has to offer, work to see that they are within the reach of his client, and that they are adequately given.

D. Using the Knowledge Gained

The knowledge which the social workers gathers is put to use by interpreting the facts. This has to be done in order to learn what is needed to help the client and how the help should be offered.

The following factors are studied and interpreted:

1. Client's overall attitude toward himself.
2. Client's attitude toward help of the social worker and others on the team.
3. Client's attitude toward reason for rehabilitation.

4. Client's attitude toward prostheses and physical supports of various kinds, physical rehabilitation, half-way measures, training work recommendations, job search, and job performance.

5. Client's attitude toward medical diagnosis and vocational plans.

He determines basic strengths or weaknesses of the client's personality, which can be worked with toward the client's rehabilitation.

E. Motivating the Client Toward Rehabilitation

In the rehabilitating process the social worker has a responsibility to help to identify the direction and potential strength of the client's motivation for recovery, training, and work. He helps the client to find this himself and put it to work in his own interest. The social worker has to have an understanding of what work, as work, contributes to the worth and dignity of people in our society. Motivation has been defined as "what an individual wants and how much he wants it."

Knowledge acquired from research and demonstration projects and other professional experiences, strongly reinforces convictions that most people want to be independent--to be well and able, to be self-sufficient. Thus, it is believed that most people have motivation. Each individual has his own image of what he wants for himself, both generally and specifically. Most individuals have within them what it takes to move on their motivation, provided they receive sufficient support in terms of practical aid and encouragement. This support, aid, and encouragement is particularly important for the public assistance recipient, and this is why the social worker's contribution to the team effort is so important. Only when the client is listened to can the nature of his problem and why he has not been

able to mobilize himself be understood. The worker needs to know the client's physical or mental impairment, his attitudes, his emotional state, and his current situation as he sees them. The plan that is developed for the client must be his.

Motivating people is a difficult task and all the agency resources need to be brought to bear in order to assure skilled casework assistance to clients in moving toward self-sufficiency.

It is essential for social workers to hold to certain definite hopeful convictions regarding individuals and their motivations, in order to make sound and worthwhile attempts to help them. These convictions are:

1. More persons really want to be self-supporting and self-sufficient than want to be parasites and failures. It is, therefore, risky to make judgements regarding any individual until it is certain that he has had his fair chance.

2. Relatively few human beings in our culture are satisfied for long with a dependency role.

3. More people want to be well and feel good than want to "enjoy poor health."

4. That often the varying weights of the "last straws" in a long series of misadventures and unfortunate circumstances cannot well be measured by another individual who is more comfortably situated.

5. Years of discouragement often create a psychic trauma that prevents the real personality and worthwhileness of the client from being recognized. As a result, special treatment in the form of psychological or psychiatric help is often needed before other rehabilitation plans can be offered or accepted.

6. Individuals are made of better "stuff" than is apparent on the surface, and the client's current situation may not indicate his possibilities for independence.

The challenge to the welfare-rehabilitation team is overcoming the most perplexing problems in rehabilitation programs today-that of motivation

toward independence and the willingness to give up the security of the known public assistance for satisfaction of self-support.

Five principles have been enumerated as basic to any program at increasing positive motivation, which are:

1. The team must have a full determination and an understanding of the full medical facts before attempting a constructive program for a person who is disabled or thought to be disabled.

2. All members of the team must have an unshakeable belief in the worth of each individual, coupled with the knowledge that basically he wants more than anything else to be a healthy, contributing member of society.

3. There must be evaluation of the person as a whole, through joint consideration by experts of several different but related professions.

4. There must be adequate understanding - both of the individual and of the group of which he is a part.

5. There must be, for the client's effective movement toward independence, action by professionally trained social workers and counselors with a high degree of competence.

Helping men and women to achieve and keep the wish to work toward a socially desirable goal is clearly not a simple process, nor something accomplished quickly. There is no magic. There can only be hard work, applied by truly sensitive, intelligent, and cooperative persons.

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REGIONAL COUNSELOR TRAINING PROGRAM

A joint program of the
West Virginia Division of Vocational Rehabilitation
and
West Virginia University
in cooperation with the
Rehabilitation Services Administration,
U.S. Department of Health, Education, and Welfare

PURPOSE

The purpose of the Regional Counselor Training Program is to establish a rehabilitation service training program which will provide introductory information and basic counseling skills to newly employed rehabilitation personnel within Region III.

This training program is made possible by grants from the Rehabilitation Services Administration of the Department of Health, Education, and Welfare. The RCTP is a division of the Regional Rehabilitation Research & Training Center.

The operation of both the RR&TC and the counselor training program is shared by the West Virginia Division of Vocational Rehabilitation and West Virginia University.

LOCATION

The site of the Regional Counselor Training Program is at the West Virginia Rehabilitation Center, Institute, located some 12 miles west of the State Capitol Building in Charleston. The Center is approximately 14 miles west of the Charleston Airport and the West Virginia Turnpike, and one mile south of Interstate Highway 64, Institute Exit.

TUITION AND STIPENDS

Tuition is $94 for students who apply for the six hours graduate credit. Tuition is paid by the enrollee's home agency. Students who do not apply for credit have no tuition cost. (All necessary material required for classwork is provided by the Regional Counselor Training Program.)

A stipend of $50 per week (total $300) will be paid to each student to help defray living expenses for the six weeks in residence at the Rehabilitation Center. Also, travel expenses will be paid for [redacted] to the Center.

1 round trip

PROGRAM CONTENTS

The training course spans a 12-week period with the first [redacted] of them spent in the classroom, the next six in on-the-job training with the student's home agency. [redacted].

The course consists of the following major units:

► INTRODUCTION TO VOCATIONAL REHABILITATION: Basic concepts of rehabilitation program philosophy; history and legal basis of the federal-state program; nature and extent of disability; the counselor and the agency; and rehabilitation research.

► INTRODUCTION TO MEDICAL ASPECTS OF REHABILITATION COUNSELING: Basic orientation to medical aspects of disability; rehabilitation implications of common disability categories; basic anatomy, and pathology; standards for adequate medical evaluation; and methods for full utilization of the medical community and use of medical consultation.

► FUNDAMENTALS OF REHABILITATION COUNSELING: Fundamentals of human growth and behavior and the core characteristics of effective interpersonal relationships are emphasized. Video-recordings of client contacts are utilized.

► SPECIAL PROBLEMS IN REHABILITATION: Discussion of selected disability problems such as mental retardation, emotional disturbances, blindness, and deafness, and other selected special emphasis areas are considered.

GRADUATE CREDIT

Upon successful completion of the 12-week training program six semester hours of graduate credit may be obtained by students who qualify for admission to the Graduate School of West Virginia University, Morgantown, West Virginia.

SCHEDULE

Classes begin the first Monday of February, April, June, August, October, [redacted]

HOUSING AND MEALS

Both housing and meals are available at the Rehabilitation Center at a nominal cost of $2 per day for each item or a total of $4 per day for both room and board.

Students may also eat in the cafeteria of nearby West Virginia State College.

HOW TO ENROLL

The Regional Counselor Training Program is open to the newly employed professional staff of vocational rehabilitation agencies within Region III.

Application is made through the State agency of the employed individual. Applications are forwarded to Rehabilitation Services Administration Regional Office, Charlottesville, Virginia. The Region III office will approve the applications and make class assignment according to the [redacted] yearly sessions.

ADDITIONAL INFORMATION

Additional information on the Regional Counselor Training Program can be obtained by writing to:

William R. Phelps, Director
Regional Counselor Training Program
West Virginia Rehabilitation Center
Institute, West Virginia 25112
(Telephone: 304, 768-8861)